Authorization for Release of Information

Door of Hope Counselling Clinic, Inc. Name of Treatment Facility
A113 - 2099 Lougheed Hwy. Port Coquitlam BC V3B 1A8 Address of Treatment Facility

This will authorize:

Ivone Juell, MA, MA, RPC, MPCC-S Name of Person (Counsellor)

To release to:

Name of Person / Organization
Address of Person / Organization

For the purpose of:

_____

_____

_____

Information from the clinical record maintained while I and / or persons under my guardian was / are a client at the above facility during _____.

Dates

I acknowledge that information to be released may include material concerning drug and alcohol and mental health treatment, which is protected by federal law. My signature below authorizes the release of all the above noted information. **I understand that all information received will be treated as confidential**.

I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purpose(s), this consent will automatically expire without any express revocation.

_____	_____	_____	_____
Client Name	Date	Counsellor Name	Date