



CREATIVE WELLNESS SERVICES

AUTHORIZATION FOR EXCHANGE OF INFORMATION

I/We _____ (client)

authorize Shelaine Grant, MSW, BSW, RSW, to release or obtain the following

information:

- Physical Health
- Psychological Health
- School planning
- Counselling progress
- Other

From _____ (physician,
therapist, other _____).

I understand I may revoke the consent at any time.

_____ Signature of client

_____ Witness

_____ Date