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