



Aram Institution

Social work, wellness and coaching institute

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Professional & Legal Framework

This consent form is developed in accordance with:

- Personal Health Information Protection Act (PHIPA), Ontario
- Standards of Practice of the College of Registered Psychotherapists of Ontario (CRPO)
- Standards of Practice of the Ontario College of Social Workers and Social Service Workers (OCSWSSW)

Aram Institution is committed to maintaining the confidentiality, privacy, and security of all client personal health information.

1. Client Information

- Full Name: _____
 - Date of Birth (YYYY/MM/DD): _____
 - Phone Number: _____
 - Email Address: _____
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2. Third Party Information (Recipient)

I authorize Aram Institution to release my confidential information to:

- Name of Individual/Organization: _____
- Relationship to Client: _____
- Phone Number: _____
- Email Address: _____

- Address: _____
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3. Information to be Released

Please check all that apply:

- Mental Health Assessment Reports
- Session Notes / Psychotherapy Notes (limited disclosure may apply)
- Treatment Plans
- Psychological / Clinical Reports
- Attendance Records
- Discharge Summary
- Risk Assessments (if applicable)
- Other (please specify): _____

Note: Some psychotherapy notes may be withheld or summarized to protect clinical integrity, in accordance with professional standards.

4. Purpose of Disclosure

The purpose of releasing this information is:

- Continuity of Care
 - Legal / Immigration (e.g., refugee claim)
 - Insurance
 - Case Management
 - Personal Use
 - Other (please specify): _____
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5. Method of Disclosure

Information may be shared via:

- Secure Email
- Fax
- Mail

- Verbal Communication (limited)
 Electronic Health Record Transfer
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6. Expiry of Consent

This consent is valid until (choose one):

- Specific Date: _____ One year from the date of signature
Until revoked in writing
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7. Client Rights and Understanding

I understand that:

- My personal health information is protected under PHIPA.
 - I have the right to refuse to sign this consent without affecting my access to services.
 - I may withdraw this consent at any time by providing written notice to Aram Institution.
 - Withdrawal of consent does not apply to information already disclosed.
 - There is a risk that once information is released to a third party, it may no longer be protected under PHIPA.
 - Only the minimum necessary information will be disclosed, in accordance with professional and legal standards.
 - My clinician may exercise professional judgment regarding the release of sensitive clinical information.
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8. Consent and Signature

I, the undersigned, voluntarily authorize Aram Institution to release the information specified above to the named third party.

- Client Name: _____
- Client Signature: _____
- Date: _____

9. Substitute Decision Maker (if applicable)

If the client is incapable of providing consent:

- Name of Substitute Decision Maker: _____
 - Relationship to Client: _____
 - Legal Authority (e.g., guardian, POA): _____
 - Signature: _____
 - Date: _____
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10. Clinician/Witness

- Clinician Name: _____
 - Designation (e.g., RP, RSW, RSSW): _____
 - Signature: _____
 - Date: _____
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Clinic Contact Information

Aram Institution – Mental Health Clinic

Address: _____

Phone: _____

Email: _____

This document is intended to meet privacy and professional standards in Ontario. Aram Institution is responsible for ensuring compliance with PHIPA and applicable regulatory colleges.