Break Free Family Centre
8-2001 Albion Road
Etobicoke, ON
Canada M9W 6v6
Phone: 416-241-9191
Fax:416-241-9195

CONSENT TO THE DISCLOSURE, TRANSMITTAL, OR EXAMINATION OF A CLINICAL RECORD UNDER SECTION 35 OF THE ACT FORM 14 – MENTAL HEALTH

I, _____

(PRINT FULL NAME OF PERSON)

of _____

(PRINT FULL ADRESS OF PERSON)

hereby consent to the disclosure, transmittal, or the examination by

Break Free Family Centre, Counsellor Keith, of the clinical record compiled in

_____

(NAME OF PSYCHIATRIC FACILITY AND OR COURT HOUSE, DETENTION CENTRE, LAWYER AND OR OTHER FACILITY)

in respect of _____.

(PRINT FULL NAME OF PATIENT/INMATE/CLIENT – INCLUDE DATE OF BIRTH)

I, _____

(PRINT FULL NAME OF PERSON)

agree to a consultation with Patricia Keith, Ph.D.

Print Name: _____ Signature: _____

State relationship (if other than patient): _____

Signature of Witness: _____

DATE: _____