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CONSENT TO RELEASE INFORMATION

I hereby, authorize _____, to obtain/release information pertaining to my evaluation and/or treatment on my file from/to:

NAME: _____
ORGANIZATION: _____
NUMBER: _____

·I have been informed that I may revoke this authorization by written or oral communication. Yes ☐ No ☐

·I certify that this form has been fully explained to me and that I understand and accept its contents. Yes ☐ No ☐

·I am fully aware and accept the legal, confidential and therapy issues that involves the release on information consent. Yes ☐ No ☐
I understand that authorization shall remain valid from the date of my signature below and ending on the following date: _____

_____ _____
Client Signature Date of Authorization

_____ _____
Therapist Signature Date of Authorization

Note:
Please note that ethical guidelines set by the Ordre des Psychologist of Quebec require that I wait 15 days from today's date before releasing information on your file.
In case of emergency or the information needs to be released immediately, ethical guidelines state that you may waive the 15-day period.

I renounce the 15 days: _____