

## CONSENT FOR DISCLOSURE

<b>File No.:</b>		
I		of <span style="border-bottom: 1px solid black;"></span>
	<small>(full name)</small>	<small>(address)</small>
hereby give consent to		<b>Temiskaming Hospital</b>
		<small>(name of party to release information)</small>
of	421 Shepherdson Rd, Temiskaming Shores, ON POJ 1PO	
	<small>(address of party to release information)</small>	
to	<input type="checkbox"/> release <input type="checkbox"/> request	
the following information:		
	<small>(description of information to be released or requested)</small>	
<input type="checkbox"/> to	<b>NEOFACS</b>	
	<small>(name of party to receive information)</small>	
<input type="checkbox"/> from		
	<small>(name of party to provide information)</small>	
in respect of		
	<small>(name(s) of client)</small>	
for:	<b>Referral purposes</b>	
	<small>(description of how information will be used)</small>	
<b>My signature on this form means that:</b>		
1. I understand this authorization and agree to its contents.		
2. I have been informed that no other information may be released without my written consent.		
3. I may rescind or amend this authorization in writing except where action has been taken in reliance on the initial authorization.		
<b>Signature:</b>		
<b>Client</b>	<b>Guardian</b>	
<b>Witness</b>	<i>Print Witness Name</i>	
	<b>Date:</b>	
<b>Expiry Date:</b>	<i>Maximum of one year</i>	
<b>Distribution:</b>		
Original	Service Provider	
Copy	Client File	