Dartmouth South Professional Centre

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Consent for the Exchange of Confidential Information

Client name: _____

Date of Birth: _____

I, _____ authorize Sarah Williams, Registered Psychologist to

(check all that apply): ☐ Release confidential information to ☐ Obtain confidential information from

Name (e.g., physician, school): _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Information to release: _____

For the purpose of: _____

I understand that I have no obligation to disclose the requested information. I also understand that this consent form remains valid from the date of signing, but can be revoked at any time by informing the practice of my wishes in writing. Revoking of consent does not apply to information that has already been released under this consent.

Name of client (Printed): _____

Signature: _____ Date: _____

If applicable- required for clients under 19 years of age

Name Parent/Legal Guardian (Printed): _____

Signature: _____ Date: _____

Name Parent/Legal Guardian (Printed): _____

Signature: _____ Date: _____