AUTHORIZATION FOR

RELEASE OF INFORMATION

FAX TO: 604-746-7399

I,____hereby authorize
(Full name of client)

Matsqui Abbotsford Impact Society to release the following information:

❑ Attendance Only, ❑ Other (describe specifics below):

contained in the clinical record of ____
(Name of client)

born______________, and pertaining from the time period from________________________to ___________________
(DOB of client) (yyyy/mm/dd) (yyyy/mm/dd)

To: (Name of persons /facility authorized to receive information) ____

____

Address of person/facility authorized to receive information) ____

____ Fax: ______________________________
for the following purposes: ❑ To Confirm Attendance, ❑ Other (clearly indicate):

DATED THIS___________________________day of___________________________, __________________________
(day) (month) (year)

CLIENT SIGNATURE : ____

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