Collaboration Consent

Share and Release of Information

Client Name and Date of Birth: _______________________________________

Clinician Name: ____

I, client name, ________________________, authorize Elm Grove Centre (or designate) to:

○ Share/ Obtain

The following information:
○ Medical history and evaluations
○ Mental health evaluations
○ Developmental, educational, social history
○ Progress and treatment goals
○ Other relevant information beneficial to client treatment and therapeutic relationship
○ All of the above

With the people identified in this collaboration request form:

Name:____
Contact Information:____

Name:____
Contact Information:____

Name:____
Contact Information:____

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice. After 1 year, this consent automatically expires.

Date: ____
Signature: ____
Witness signature (if client is unable to sign or is a minor): _______________________

Elm Grove Centre Mental Health Services
41097 Western Rd, Alma, PE C0B1K0
Email: therapy@elmgrovecentre.ca
Phone: 902-806-2257
Fax: 902-853-2342
Founder and Owner: Josée Gallant-Gordon, M.S.W., R.S.W.