Chatrath Counselling Centre

Authorization for Exchange of Information with a Third Party

I/We _____ (client and parent/guardian if applicable) authorize _____ (clinician name, credentials), of Chatrath Counselling Centre, to release and/or obtain the following information:

- Physical Health ____ (Client Initial)
- Psychological Health ____ (Client Initial)
- Counselling process and progress ____ (Client Initial)
- Legal Concerns ____ (Client Initial)
- Other ____ (Client Initial)

  _____

  _____

to and from (name, address, contact information)

_____

_____

_____ (physician, therapist, lawyer, other) as it pertains to _____ (client name).

I understand I may revoke this consent at anytime through written communication.

_____ (Signature of Client)

_____ (Date)

_____ (Signature of Counsellor)

_____ (Date)