Cambridge Community Outreach Group

A Service of Kings Regional Rehabilitation Centre

AUTHORIZATION FOR
CAMBRIDGE COMMUNITY OUTREACH GROUP
CONSULTATION AND RELEASE OF INFORMATION

Name: _____

Date of Birth (M/D/Y): _____

I, _____, give permission to _____
(Please Print) (Please Print)

or designated representatives of the Cambridge Community Outreach Group of Kings Regional Rehabilitation Centre, to consult with my supporting agencies/family members, assess my needs, make recommendations for intervention strategies, and/or implement intervention procedures.

Recommendations from the assessment, including potential benefits and risks, will be discussed with me and relevant support persons.

Authorization is hereby granted to release confidential information as deemed necessary to persons or agencies who may be involved with my care through consultation with the Cambridge Community Outreach Group.

I understand this release is valid for one year from the date of the last signature. This consent to release information can be withdrawn at any time when I provide a written request.

Date: _____ Signed: _____

Witness: _____ Guardian/Next of Kin: _____

Relationship to Client: _____

Form # 262

Notes/Questions/Comments:

_____

_____

_____

_____

_____

Subsequent Consent for Release of Confidential Information:

Witness: _____ Client/Guardian: _____ Date: _____

Witness: _____ Client/Guardian: _____ Date: _____