

<b>Child's Legal Name</b>	
<b>Date of Birth (yyyy-Mon-dd)</b>	<b>Personal Health Care Number</b>

I, \_\_\_\_\_ authorize individually identifying  
*Legal Representative (LegalGuardian)*

diagnostic, treatment and care information for \_\_\_\_\_ to be  
*Name of Child*

disclosed or obtained by Allied Health Services for Children, in accordance with Section 34 of the *Health Information Act*, for the purpose of assessment, treatment and/or treatment planning for my child (which may include assessment reports and program information), to or from the following.

**Write out the name(s) of applicable individuals/agencies in the space provided.** (Checkmarks not accepted.)

School or School Division: \_\_\_\_\_

Family Doctor/Pediatrician: \_\_\_\_\_

Other Healthcare Professionals: \_\_\_\_\_

Other Agencies: \_\_\_\_\_

Foster Parent(s): \_\_\_\_\_

Other: \_\_\_\_\_

I understand why I have been asked to disclose individually identifying information, and am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure of this individually identifying information. I understand that this request may be revoked at any time.

**Date:** \_\_\_\_\_ **Expiry Date (if any):** \_\_\_\_\_  
*(yyyy-Mon-dd)* *(yyyy-Mon-dd)*

X  
\_\_\_\_\_  
**Legal Representative's Signature**

\_\_\_\_\_  
**Relationship to the Child** (If you are not the legal guardian, provide the guardian's name & phone #)

\_\_\_\_\_  
**Legal Representative's Name (please print)**

X  
\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_  
**Witness Name (please print)**