GENESIS CONSULTING PSYCHOLOGISTS

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CONSENT TO DISCLOSE AND/OR RECEIVE INFORMATION

I, Mr./ Ms. _____ hereby authorize _____

to:

____ A. Send copies or provide information verbally concerning my assessment, treatment plan, progress notes, discharge summary and follow-up reports to the individual(s) listed below:

____ B. Communicate with the following individuals to receive information concerning my psychological status, my treatment, my medical status, or other information relevant to my psychological assessment and/or treatment.

_____	_____
Rehabilitation counsellor	(WSIB) Family physician
_____	_____
Rehabilitation consultant	Specialist
_____	_____
Insurance company	Other (please specify) _____

I have read and understand this information and provide my consent by signing and initializing this form.

I also understand that this consent is valid for 12 months but may be revoked at any time, except in the case where the fee for the service is provided by a third party (for example: WSIB, Insurance company, etc). In such a case, my consent to disclose information to all other people listed above can be revoked, but not for the party paying for the service.

_____	_____
Client's signature	Date
_____	_____
Witness	Date