Mindy Bilotta Counselling & Parenting Support
29 Wilfrid Laurier Cres. St. Catharines, ON L2P 0A4 www.mindybilotta.ca
melindabilotta@gmail.com 289-686-0903

Authorization for Release of Information

Client's Name: _____DOB:_____

Information to be released:

- ☐ Summary of treatment to date
- ☐ Report
- ☐ Other: _____

Purpose of Disclosure:

- ☐ Coordination of Care
- ☐ Other:_____

Persons authorized to make Disclosure:

Person authorized to receive Disclosure:

Method of Disclosure:

- ☐ Written
- ☐ Verbal
- ☐ Electronic

Today's date:_____ Authorization to expire on: _____

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing.

Signature of Patient: _____Date: _____

Signature of Personal Representative:_____