Purposeful
COUNSELLING
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Authorization to Release Information

I, _____ authorize Kyla Bernardo, M. Ed, C.C.C., to release or obtain the following information:

- Physical health
- Psychological health
- Counselling progress
- Legal Concerns
- Other: _____

For the purpose of (eg. disclosure, continuity of care):_____,

to be disclosed to or obtained from: _____.

This consent is valid for:

( ) one year
( ) this request only
( ) expires on: _____
Date (day, month, year)

I understand that my health information is protected by law. I authorize the release of my personal 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.

Client Name: _____

Client Signature: _____

Date: _____