WILP SI'SATXW COMMUNITY HEALING CENTRE
Box 429, Kitwanga, BC, V0J 2A0 Ph:
250 849 5211 I Fax: 250 849 5374
Toll free: 877 849 5211
info@wilpchc.ca

CONSENT FOR RELEASE OF INFORMATION

This section is to be filled out if referral is made and client information is required.

Client Name: ____

Date of Birth: Day ________ Month __________________ Year ____________

I, ______________________________________ *(client's name)*, hereby give my permission for Wilp Si'Satxw Society Community Healing Centre, P.O. Box 429, Kitwanga, BC V0J 2AO.

To contact *(name and address of agency providing information)*

Name: ____

Address: ____

For information to be released, limited to *(describe type(s)* of information to be released).

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I understand that no other information will be released to any other persons without my written consent unless these persons have a court order or are concerned with my medical treatment in an emergency situation. I also understand that I can withdraw or amend my consent to the release/request of information at any time.

Start date of consent ______________________. End date of consent ______________________

In order for this release to be valid, it must be completed in its entirety.

Client's Signature: ______________________________ Date: ______________________

Witnesses by: ______________________________ Date: ______________________
(this may be referring person or assessor)