LMCAAS

Rey T. Singh MSW, RCS, CACII, RCS
Social Work Therapist

CONSENT TO THE DISCLOSURE/TRANSMITTAL OF CLINICAL INFORMATION RECORDS

I, _____, _____
PLEASE PRINT (Surname) **(Given Name)**

of: _____
(Address)

Hereby authorize_____of:_____to transmit, or disclose clinical information to (please indicate address if known):

_____

Rey T. Singh MSW, RSW, CACII, RCS at London Middlesex Counselling & Addiction Services at 211-186 King St, London, On. N6A 1C7_____

In respect of: _____
(Client's Full Name) **(Date of Birth)**

Description of information to be transmitted/disclosed:

☐ Any pertinent information
☐ Specifically: _____
_____

I, also consent for Rey T. Singh MSW, RSW, CACII, RCS to transmit and disclose work completed in counselling sessions back to the referral representative named above. _____(Client Initials)

This consent is valid for the length of time the person/client or client family is receiving service from London Middlesex Counselling & Addiction Services OR two (2) years from date of signature. I understand that I may revoke this consent in writing at any time.

This consent for transmittal or disclosure has been fully explained to me. I understand it and agree with the transmittal or disclosure.

_____ _____
(Signature of Witness) **(Client Signature)**

Dated the _____ day of _____, 20_____

Rey T. Singh MSW, RSW, CACII, RCS
London Middlesex Counselling & Addiction Services
Rm 211- 186 King St. London, Ontario, N6A 1C7
Telephone: (519) 679-7250 Fax: (519) 204-3886

Revised: 31-October 2016