**RJ Therapy**

**3169 McLeod Rd**

**West Kelowna, BC**

**(778) 754-7977**

**AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION**

This form cannot be used for the re-release of confidential information provided to RJ Therapy by other individuals or agencies. Such requests should be referred to the original individual or agency.

I ­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Ryan Hendricks at RJ Therapy to:

 \_\_\_\_\_ release to:

 \_\_\_\_\_ obtain from:

 \_\_\_\_\_ exchange with:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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the following information pertaining to myself:

 \_\_\_\_\_ assessment and treatment records

 \_\_\_\_\_ dates of treatment attendance

 \_\_\_\_\_ other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

for the purpose of:

\_\_\_\_\_ evaluation/assessment and/or coordinating treatment efforts

 \_\_\_\_\_ other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent will automatically expire one (1) year after the date of my signature as it appears below.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

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Signature of Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Witness Date