

HopeWell Psychological Inc.

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HOPEWELL
PSYCHOLOGICAL

CONSENT TO OBTAIN OR RELEASE CONFIDENTIAL INFORMATION

Client Name: _____ **(Please Print)**

Client Name: _____ **(Please Print)**

I, _____ **(Print name of Client/Parent/Legal Guardian)**
hereby authorize HopeWell Psychological to obtain/release information to/from:

Name: _____

Address _____

Phone: _____

For the purpose(s) of _____

I understand that I give consent concerning my personal information, which by law may be considered confidential or privileged. I understand that the information released by this consent cannot be released to any other person unless I have given my written permission.

My signature indicates that I have read this form and/or it has been explained to me in language that I understand.

This consent form expires one (1) year from the current date undersigned, unless revoked in writing by the client prior to that date.

Client Name

Client Signature

Date

Client Name

Client Signature

Date

Parent/Guardian Name

Parent/Guardian Signature

Date

Counsellor Name

Signature

Date