Willow Winds
SUPPORT NETWORK
NWC Alberta FASD SVC NTWK SCTY

Site 1 Comp 8 RR 001 Canwood, SK S0J 0K0
780-305-8757 or 780-974-7112
jennp@wwsn.ca

Assessment & Diagnostic Service
Consent to Release Information

I,____________________________(full legal name of adult client), born___________(dd/mmm/yyyy) hereby authorize the Willow Winds Support Network to RELEASE the following information verbally or in writing.

This information is to be released to the following identified sources. Please specify the information to be RELEASED by **selecting the corresponding letter** from list below (i.e. A-F) **AND** by placing your **INITIALS** beside each selected item.

A. Assessment & Diagnostic Services Summary Report and Recommendations (Short 1-Page Summary Report)
B. Psychological Assessment Report
C. Speech Language Assessment Report
D. Occupational Therapy Assessment Report
E. AISH, Income Support, PDD, FASD Advocates
F. All Reports Listed Above

Initials	Information	Source
__________	________________	Physicians
__________	________________	AISH, Income Support, PDD, FASD Advocates
__________	________________	Probations, Correctional Facilities, Lawyers
__________	________________	Addictions, AHS, AMHS

______________________________ ________________________
Signature of Client Date

______________________________ ________________________
Signature of Witness Date

____
Print Name of Witness

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Adult Assessment & Diagnostic Services
Consent to Obtain/Release Information

I,____(full legal name of client), born____________________________(yyyy/mmm/dd) hereby authorize the Willow Winds Support Network to OBTAIN/RELEASE confidential information verbally or in writing for the purpose of coordinating an assessment and diagnosis, developing continuum of care recommendations, and to make appropriate referrals.

This consent form is to be effective for the duration of the client's involvement with the assessment, diagnostic, and intervention services and may be withdrawn by the client at any time during this process.

Name and address of individual/agency(ies) from/for whom information is to be obtained/released:

Willow Winds Support Network
Contact: Jennifer P
Jennp@wwsn.ca

____________________________ ____________________________
Signature of Client Date

____________________________ ____________________________
Signature of Witness Date

____
Print Name of Witness

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Assessment & Diagnostic Services
Authorization to Obtain Information

I, ______________________________ (full legal name of adult client), born (dd/mm/yyyy) hereby authorize the Northwest Central Alberta Fetal Alcohol Spectrum Disorder Network to obtain the following information verbally or in writing.

Please INITIAL and place an (*) beside the information to be obtained.

- ☐ ________ Birth records and any other medical records in the file. (Including newborn discharge summaries, nursing notes and immunization records)
- ☐ ________ Psychological, mental health, speech, language and any other assessments and reports
- ☐ ________ Past and current educational records
- ☐ ________ Justice or Correctional Services Information, reports and history
- ☐ ________ Children's Services Records
- ☐ ________ Other: ____

This information will be used to assist the Northwest Central Alberta FASD Network Diagnostic team to determine a diagnosis, develop continuum of care recommendations and to make appropriate referrals.

This consent form is to be effective for the duration of the client's involvement with the assessment, diagnostic and intervention services and may be withdrawn by the client/legal guardian at any time during this process.

______________________________ ______________________________
Signature of Client Date

______________________________ ______________________________
Signature of Witness Date

____
Willow Winds Support Network
Assessment & Diagnostic Services

Willow Winds
SUPPORT NETWORK

Box 5389 Westlock, AB T7P 2P5
780-305-9547 or 780-974-7112
jennp@wwsn.ca

Name of Witness