Willow Winds
SUPPORT NETWORK

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

Assessment & Diagnostic Service
Consent to Release Information

I, _____, born _____
FULL LEGAL NAME OF ADULT CLIENT — MM / DD / 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 (ex: 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 (MM / DD / YYYY)

_____ _____
SIGNATURE OF WITNESS — DATE (MM / DD / YYYY)

_____
PRINT NAME OF WITNESS