Peace Country Health
MENTAL HEALTH
Student Health Program

CONSENT TO THE DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE INFORMATION

I, ____, authorize the following individually identifying information:

- Information included in my child's cumulative school record file
- Any assessment completed by the school

for ______________________________ to be disclosed by ________________________________,
Name of child | Name of School

to the Student Health Program for the following purpose(s):

- To assist my child with problems identified by parents and school

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I understand why I have been asked to disclose individually identifying information, and am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure of this individually identifying information. I understand that this request may be revoked at any time.

Date: ______________________________ (DD/MM/YY)

Expiry Date (if any): __________________________ (DD/MM/YY)

____
Client or Legal Representative's Signature

____
Source of Representative's Legal Authority

____
Client or Legal Representative's Name (please print)

____
Witness Signature

____
Witness Name (please print)