

**Fetal Alcohol Spectrum Disorder  
 Assessment and Diagnostic Services  
 Pre Clinic Consent for the Collection/Receipt of Personal or Confidential  
 Information**

I, \_\_\_\_\_ (Legal Guardian), authorize and give permission to Lethbridge Family Services to receive information either verbally or in writing from the following:

- |   |   |
|---|---|
| <input type="checkbox"/> Birth Records                  | <input type="checkbox"/> Health Records                 |
| <input type="checkbox"/> Mental Health Records          | <input type="checkbox"/> Addiction Records              |
| <input type="checkbox"/> School Records                 | <input type="checkbox"/> Children Services Records      |
| <input type="checkbox"/> Assessment Reports/Information | <input type="checkbox"/> Justice Records                |
| <input type="checkbox"/> Caregivers                     | <input type="checkbox"/> Specialist Records/Assessments |
| <input type="checkbox"/> Other (please list): _____     |   |

**Purpose of the Information:**

This information will be used to assist the FASD Assessment and Diagnostic Services team to determine a diagnosis, develop recommendations, and decide on appropriate referrals.

**Consent for the Request/Release of Personal or Confidential Information**

Information may be requested/released to the following:

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Alberta Health Services                  | <input type="checkbox"/> Trustee             | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Schools                                  | <input type="checkbox"/> Employment Agencies | <input type="checkbox"/> CFSA         |
| <input type="checkbox"/> Service Agencies                         | <input type="checkbox"/> Justice             | <input type="checkbox"/> Caregivers   |
| <input type="checkbox"/> Additional Supports (please list): _____ |  |                                       |
| <input type="checkbox"/> Other (please list): _____               |  |                                       |

I understand why I have been asked to disclose this information. I am aware of the risks or benefits of consenting, or refusing to consent to the disclosure of this information. This consent is effective for the duration of the client's involvement with the FASD Assessment and Diagnostic Services and may be withdrawn, by written notice, from the Legal Guardian at any time. A photocopy or facsimile of this form shall be deemed valid as an original.

**Client's Name:** \_\_\_\_\_ **Client's PHC#:** \_\_\_\_\_

**Client's DOB:** \_\_\_\_\_

\_\_\_\_\_  
 Signature of Legal Guardian                      Print Name                      Date

\_\_\_\_\_  
 Signature of Legal Guardian                      Print Name                      Date

\_\_\_\_\_  
 Witness                      Date                      Date Consent Expires

DC 01/22