

Fetal Alcohol Spectrum Disorder Assessment and Diagnostic 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"/> Psychological Assessments | <input type="checkbox"/> Justice Records |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Speech Language Assessments |

Purpose of the Information:

This information will be used to assist the FASD Assessment and Diagnostic Clinic team to determine a diagnosis, develop recommendations, and make referrals.

Consent for the Request/Release of Personal or Confidential Information

Information may be requested/released to the following:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Family Physician | <input type="checkbox"/> Guardian/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"/> AHS | <input type="checkbox"/> Justice |
| <input type="checkbox"/> Other _____ | | |

I understand why I have been asked to disclose this information and I am aware of the risks or benefits of consenting, or refusing to consent to the disclosure of this information. This consent form is to be effective for the duration of the client's involvement with the FASD Assessment and Diagnostic Clinic team and may be withdrawn, by written notice from the guardian at any time.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 |
|---|----------------------------|----------------------|

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|-------------------------|----------------------|--------------------------------------|
| _____ Witness | _____ Date | _____ Date Consent Expires |
|-------------------------|----------------------|--------------------------------------|