REHABILITATION CENTRE FOR CHILDREN

633 Wellington Cres
Winnipeg, MB R3M 0A8
PH: (204) 452-4311
FAX: (204) 477-5547

Authorization to Release Information

I, _____ parent/guardian of _____
(Child's Name)

Date of Birth: _____, give permission for the Rehabilitation Centre for Children to provide information about my child's physiotherapy or occupational therapy program to the services I have designated below. This information may be in writing or be given verbally at meetings.
Day/Month/Year

Please provide the name, address & phone # for those services or agencies your authorize the Rehabilitation Centre for Children to provide information to.

Name of Service or Agency	**Name, address & phone # (if available)**
❑ Family Doctor or Pediatrician	_____
❑ Medical Specialist(s)	_____
❑ Social Worker / Counsellor (CSS, SMD)	_____
❑ Child Guidance Clinic or Educational Support Services (SLP, psych, reading)	_____
❑ School or School Division	_____
❑ Hospital Therapist(s)	_____
❑ Private Therapist(s)	_____

Others: (please provide name, address & phone #)

_____

_____

Is there anyone that you **do not** want us to share information with?

_____

_____

_____ **Date:** _____
Signature of Parent or Guardian

_____ **Date:** _____
Signature of Witness

Unless notified by parent/guardian in writing, this release will remain valid.