

# *REGIONAL SUPPORT ASSOCIATES*

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## CONSENT TO SHARE INFORMATION

I, \_\_\_\_\_,  
*Name*

Of \_\_\_\_\_  
*Address City Postal Code*

Hereby authorize *Regional Support Associates* to disclose (receive and/or send) the following information:

From/To the following agencies for the purpose of assessment and/or treatment,

In respect of: \_\_\_\_\_ DOB: \_\_\_\_\_  
*Name of Client Date of Birth*

**TO: (List Agency or Organization Below) Please Note:** *Client's authorization is required in the form of initial if more than one agency is listed below. If client prefers, individual consent forms can be used for more than one agency/organization.*

\_\_\_\_\_  
*Client's Initial Agency/Organization*

\_\_\_\_\_  
*Signature of Person Referred Date*

\_\_\_\_\_  
*Signature of Legal Guardian or Substitute Decision Maker Relationship to Person Referred*

\_\_\_\_\_  
*Signature of Witness Date*

**Please Note:** The opportunity to be informed and to complete this Consent to Share Information must first be given to the person referred. Where the person referred is not of legal age or lacks legal capacity to give consent, this consent is to be signed by a Legal Guardian or Substitute Decision Maker. When the Substitute Decision Maker signs consent, the relationship to the person referred must be stated. Furthermore, when the consent is given by the Substitute Decision Maker and/or Legal Guardian, it is most desirable to obtain the consent and signature of the person referred as well, provided he or she has been fully informed as much as possible. The person referred or the Substitute Decision Maker and/or Legal Guardian have the right to withdraw consent for *Regional Support Associates* to share information even after this consent is signed.