**Comox Valley Child Development Association**

**Authorization to Release Information**

I, _____, authorize the Comox Valley Child Development Association to release copies, extracts or summaries of ASSESSMENTS, REPORTS, HISTORIES, and/or INFORMATION prepared by their programs to the following agencies, as needed to enhance service delivery. Please fill in the name of a contact if known, and sign after each identified agency/person.

___ I consent to the electronic transmittal via email of ASSESSMENTS, REPORTS, HISTORIES and/or INFORMATION produced by the Comox Valley Child Development Association in regards to service delivery. _____(signature)

If you do NOT consent to release any information. Please indicate and sign here:_____(signature)

| **Service Provider** | **Contact (if known)** | **Signature** |
|---|---|---|
| Family Physician | | |
| Pediatrician | | |
| Island Health (Public Health Nurse, hospital social worker) | | |
| Ministry of Children and Families | | |
| Community Living BC | | |
| Child and Youth Mental Health | | |
| Family Services | | |
| Child Care Facility | | |
| Behaviour Consultant | | |
| School District | | |
| Medical Specialist | | |
| Medical Specialist | | |
| Other Practitioners (Chiropractor, Nutritionist, Acupuncturist) | | |
| Other Custodial Parent (if not residing with child) | | |
| | | |
| | | |

**Date** _____

(Valid for one year from this date, unless revoked in writing)