COMOX VALLEY
Child Development Association

UWONA
Some programs operated through
Upper Island Women of Native Ancestry
960 Cumberland Rd, Courtenay, BC, V9N 2E4

AUTHORIZATION TO RELEASE AND OBTAIN INFORMATION

I,_____the UNDERSIGNED PARENT/GUARDIAN of

the CHILD_____ DOB _____(Y/M/D), authorize

Comox Valley Child Development Association (CVCDA) to electronically transmit via:

- ☐ email
- ☐ text

the following items related to my child and services they receive from CVCDA:

- ☐ assessments,
- ☐ reports,
- ☐ histories
- ☐ information prepared by their programs
- ☐ photos
- ☐ videos

Email: _____

Current Address: _____

Phone Number: _____

☐ I authorize CVCDA to **release and obtain** copies, extracts or summaries of ASSESSMENTS, REPORTS, HISTORIES and/or INFORMATION prepared by their programs **to/from** the agencies and people listed on this form, as needed to enhance service delivery to my child.

Family Signature: _____ Date:

This consent is valid for one year from today ___insert date___ unless revoked in writing.

Both when changes are made after signing and at annual review of consent a new signature and date must be recorded below. Consent remains valid for one year from date of most recent signature:

FOR INTERNAL USE ONLY:

Date of first review: _____ Review Signature: _____

Date of second review: _____ Review Signature: _____

Service Provider	Contact Full name & Location (if known)	Parent/Legal Guardian Signature
Family Physician		
Pediatrician		
VIHA (Public Health Nurse / Speech & Hearing Clinic)		
Medical Specialist		
Other Practitioners e.g. chiropractor, nutritionist, private OT / SLP / physio, behaviour consultant		
MCFD		
CYSN		
Child & Youth Mental Health		
Family Services		
Preschool/ Daycare		
UIWONA-AIDP		
School District		
Foster Parents	Name: Address:	
Parent (if not residing with child)	Name: Address:	
Other – must specify: _____		