



I, _____
(print full name of person)

of _____
(address)

hereby consent to the disclosure or transmittal to or the examination by _____
(print name)

of the clinical record compiled in _____
(name of psychiatric facility)

in respect of _____
(name of patient) (date of birth, where available)

(witness)

(signature)

(if other than the patient, state relationship to the patient)

Date _____
(day / month / year)

(Disponible en version française)