**UBC Psychology Clinic**

2136 West Mall, Vancouver, BC, V6T 1Z4

Phone: 604-822-3005⏐Fax: 604-822-6923

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**Consent to Release and Receive Information**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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initial

I hereby authorize the UBC Psychology Clinic to **release** information concerning my case, with the noted limitations, to the person or agency listed below.

initial

I hereby authorize the UBC Psychology Clinic to **request and receive** information concerning my case, with the noted limitations, from the person or agency listed below.

I understand that I may revoke or amend this consent in writing at any time.

Agency or Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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This request is confined by the following limitations:

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Date Client Signature

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Witness