

THE TREATMENT CENTRE FOR THE HEALING ARTS
Disclosure Request Form

I understand that my health information is private and that use of my health information must be consistent with the Centre's Notice of Privacy Practices. I further understand that certain disclosures of my health information may only be provided by my written consent. I therefore make the following request, and understand I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

I, _____
(Printed Name of Client/Patient)

request or authorize the Treatment Centre for the Healing Arts to disclose to:

(Name of Person or Agency)

the following information: _____
(Nature of Disclosure)

for the purpose of _____
(Need for Disclosure)

This consent expires automatically upon the following date, event or condition:

Client/Patient Signature: _____ Date: _____

Signature of Witness: _____ Date: _____

For Office Use:

___ Disclosure implemented _____

___ Disclosure denied - Reason for Denial _____

Staff Signature: _____

Date: _____