

**AMBER OKE-MAC NEIL, MSW, RSW, CSFT  
Psychotherapy and Counselling**

**CONSENT FOR DISCLOSURE OF INFORMATION**

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**File Name:** \_\_\_\_\_ **File Number:** \_\_\_\_\_

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**I, (name)** \_\_\_\_\_,

**hereby provide my informed consent and authorize (name and organization)**

\_\_\_\_\_ ,  
**to release information to (name, title, organization, address)** \_\_\_\_\_

\_\_\_\_\_  
**concerning (names)** \_\_\_\_\_

\_\_\_\_\_ .  
**I give this consent acknowledging that (YOUR NAME) has fully explained the following:**

**1) The information is required because:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**2) The receiving party will use my information to:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**3) The receiving party may pass the information on to a third party:** \_\_\_\_\_

\_\_\_\_\_



4) The potential repercussions of giving consent are: \_\_\_\_\_

\_\_\_\_\_

5) The potential repercussions of refusing permission for the disclosure: \_\_\_\_\_

\_\_\_\_\_

6) I can revoke this consent by calling (YOUR NAME) at (PHONE) and requesting this.

7) Only the following information will be disclosed by (YOUR NAME): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

8) This consent will be valid from (date) \_\_\_\_\_

until (date) \_\_\_\_\_.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship: \_\_\_\_\_

Date: \_\_\_\_\_ Witness: \_\_\_\_\_