t h e o w e n s g r o u p p s y c h o l o g y

Dr. Katherine Owens

Registered Doctoral Psychologist

Consent for Release of Information

I, _____ *(name)*, of _____ *(address)*, hereby authorize Dr. Katherine Owens to (i) provide written and/or verbal intake, assessment, progress, discharge or follow-up reports to the applicable parties listed below, (ii) contact the listed parties for the purpose of obtaining information regarding the injury, assessment, treatment, or discharge, and to (iii) retain their applicable health information in a secure file for 7 years upon which point the material will be destroyed.

This authorization extends to the following parties:

Specified Party	Yes	No	Initial
1. CBI Physical Rehabilitation			
2. WCB			
3. SGI			
4. Alliance Health Medical Clinic			
5. Gateway Alliance Medical			
4. Family Physician (_____)			
5. Family Member (_____)			
6. Physician Specialist (_____)			
7.Team Doctor (_____)			
8.			
9.			

Reports may be withheld until payment has been made. Billing and payment information will have been discussed and agreed to by all parties prior to this assessment

LIMITS TO CONFIDENTIALITY

In the case of an assessment for an insurer, any information collected can be communicated to involved parties including your insurer. Also, Dr. K. Owens and her students or staff members are able to break confidentiality if it is felt that a client represents a threat to self, others, if a child is in need if protection, if required by SGI, or if required by a court of law. De-identified data is entered into a group database for future statistical analysis/research.

I have read and understood the above authorization and indicate my consent by my signature. This authorization will be valid for twelve (12) months from this date or until _____.

_____ _____

Signature of Client or Duly Authorized Representative

Date