



REACH AUTHORIZATION FOR RELEASE OF INFORMATION

FORM B-2

STUDENT INFORMATION:

Student Name: _____ Date of Birth: _____
(month/day/year)

Family Physician: _____ Address: _____

Other Physicians: _____ Address: _____
_____ Address: _____

BACKGROUND INFORMATION:

Please indicate if your child has been involved with any of the following professionals/agencies during the past two years:

- | | Professional's Name | Agency/Clinic |
|-------------------------------------------------------------------------------------------------------------------------------|---------------------|---------------|
| <input type="checkbox"/> Audiologist | _____ | _____ |
| <input type="checkbox"/> Occupational Therapy | _____ | _____ |
| <input type="checkbox"/> Optometrist/Ophthalmologist | _____ | _____ |
| <input type="checkbox"/> Physical Therapy | _____ | _____ |
| <input type="checkbox"/> Psychologist | _____ | _____ |
| <input type="checkbox"/> Speech Language Pathologist | _____ | _____ |
| <input type="checkbox"/> Canadian National Institute for the Blind (CNIB)
CNIB No _____ Registered _____ or Enrolled _____ | | |
| <input type="checkbox"/> Alberta Children's Hospital (ACH) (Specific Clinic/Services) | _____ | _____ |
| <input type="checkbox"/> Glenrose Rehabilitation Hospital (Specific Clinic/Services) | _____ | _____ |
| <input type="checkbox"/> Other (specify) | _____ | _____ |

Authorization

I understand why I have been asked to disclose this information and am aware of the risks or benefits of consenting or refusing to consent to disclose this information. All information will be treated as confidential and is for educational programming purposes. I also understand that I may revoke this consent at any time by submitting a written revocation document to the requested site.

Yes No I authorize release of REACH reports on the above named child to outside agencies for the purpose of referrals and/or medical/clinical reviews.
Parents/guardians will be notified before information is sent to outside agencies.

Yes No I hereby authorize release of records on the above-named child from the above-named practitioners/agencies to:
Supervisor, REACH, 5505 – 4A Street S. W. Calgary, AB T2V 0Z7
Ph: 403-777-6983 Fax: 403-777-6997

Signature of Parent/Guardian

Date

Parent/Guardian (Please print)