Children's Therapy and Family Resource Centre

801 McGill Road, Kamloops, BC V2C 6R1 Phone: (250) 371-4100 Fax: (250) 371-4120
www.kamloopschildrenstherapy.org

Child's Name: _____ Date of Birth: _____

CTFRC Consent to Obtain and Release Information

To provide safe, effective, coordinated services CTFRC staff need to request and share information with your child's other service providers. All information is treated as strictly confidential. A copy of this consent will be sent to all persons/agencies when information is requested from them. CTFRC reports are always sent to parent(s) and/or legal guardians.

Consent to Obtain **Please initial**	Current Service Providers (a change in provider will not negate general consent)			Consent to Release **Please initial**
	Service Provider		**Name**	
	Family Physician			
	Pediatrician			
	Infant Development Program			
	Preschool/Daycare			
	Foster Family			
	MCFD			
	Child & Youth with Special Needs			
	Secwepemc Child & Family Services			
	LMO Family & Community Services			
	Interior Community Services			
	Interior Health Authority	Public Health Nurse		
		Dietician		
		Speech Therapist		
		Audiologist		
	Child & Youth Mental Health			
	BC Early Hearing Program			
	Behavioral Consultant/Interventionists(s)			
	Autism Diagnostic Team (Coordinator, Interior Children's Assessment Network, Psychologist, SLP, OT, Pediatrician)			
	BC Women's and Children's Hospital			
	Sunny Hill Health Centre			
	Royal Inland Hospital			
	Private Therapy Services	Physiotherapy		
		Speech Therapy		
		Occupational Therapy		
	Equipment Dealer			
	Orthotics/Prosthetics Services			
	School District (for children entering kindergarten)			
	Other Agency/Person			
	Other Agency/Person			

Please turn over.....

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Please initial:

- ☐ I hereby give my consent to allow audio/visual records to be taken for the use of my child's treatment. This information may be shared with the child's CTFRC team.
- ☐ I hereby authorize the staff of CTFRC to help my child with toileting needs as required.
- ☐ I give my consent to allow CTFRC staff to communicate with me and send reports/information regarding my child by email.
- ☐ I give consent for CTFRC staff to communicate with me via texting.
- ☐ I have been given information on my rights and responsibilities and the Welcome to CTFRC information sheets.

Additional Legal Guardian(s)/guardians at a separate address

Name(s): _____ **Email:** _____

Address: _____
Street address **City** **Postal Code**

Home Phone: _____ **Cell/Work Phone:** _____

Relationship to Child:

☐ Biological Mother / Father ☐ Adoptive Mother / Father ☐ Social Worker

☐ Other Legal Guardian: _____

This Guardian will receive all information about the services being provided: Yes ☐ No ☐

NOTES:

Please note: Both Legal Guardians may be required to sign consent forms.
Consent expires 1 year from signing.

X_____	X_____	X_____	X_____
Signature of Legal Guardian	Please Print Name	Relationship to Child	Date
X_____	X_____	X_____	X_____
Signature of Legal Guardian	Please Print Name	Relationship to Child	Date