



I, \_\_\_\_\_  
(print full name of person)

of \_\_\_\_\_  
(address)

hereby consent to the disclosure or transmittal to or the examination by \_\_\_\_\_  
(print name)

of the clinical record compiled in \_\_\_\_\_  
(name of psychiatric facility)

in respect of \_\_\_\_\_  
(name of patient) (date of birth, where available)

\_\_\_\_\_  
(witness)

\_\_\_\_\_  
(signature)

\_\_\_\_\_  
(if other than the patient, state relationship to the patient)

Date \_\_\_\_\_  
(day / month / year)

*(Disponible en version française)*