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**INTERAGENCY CONSENT FORM TO OBTAIN AND RELEASE**

**CONFIDENTIAL INFORMATION**

I,  , of

*Full Name of Person Address*

authorize the sharing of information for the purpose of assessment/treatment among

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*Department/Agency*

And: (please check in appropriate boxes)

Department of Justice

Department of Community Services

Nova Scotia Health Authority – Mental Health Services

Family and Children’s Services of Lunenburg County

Family and Children’s Services of Queens County

Addiction Services

South Shore Regional Centre for Education (69 Wentzell Dr., Bridgewater, NS

B4V 0A2)

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exceptions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name: Date of Birth (m/d/y):

Parent/Guardian(s):

Witness:

Location: Date:

**All of the above agencies are bound by strict policies of confidentiality and cannot release or receive your personal information without your authorized consent.**