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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

 .

 *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.**