

**Obtain and Release of Information**

*In connection with programming services provided to me under the direction of Key Connections Consulting Inc. (KCC)*

I authorize KCC to ***obtain/release*** *information* regarding my program and services, from all relevant parties as follows:

* Family Supports for Children with Disabilities
* Children’s Allied Health Services
* REACH
* Pediatrician
* Family Doctor
* Alberta Children’s Hospital
* School/Preschool/Daycare
* Persons with Developmental Disabilities
* Psychologist Contracted by KCC
* Pivotal Response Treatment (PRT) consultation
* CBI Greystoke Home Health
* QUEST Support Services
* PEAK Vocational Services
* Southwest Alberta Child and Family Services
* Other (Mental Health, Counselling, Psychologist)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Applicable Conditions or Restrictions:***

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**Consents For Service**

I understand that Key Connections Consulting services may include:

* Assessment
* Consultation
* Group Intervention
* Hand-over-hand contact

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***Client’s Name***

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***Parent/Guardian Signature Date***

**Acknowledgement**

I will hold Management, staff, and other relevant parties of Key Connections Consulting Inc. free of liability for the exchange of this information and any other reasonable and necessary information incident to the program process.

I have read and understand this agreement. I have been informed of my right to give, withhold, and revoke such consent and I sign this without any coercion or duress by any individual or institution. This act is entirely voluntary on my part.

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***Authorized Signature – Parent/Guardian*** ***Date***