Consent for the Release of Information

To release information to Dr. Ryan Chan

Child's Name (Last, First)_____ DOB _____

Legal Guardian Name (Last, First) _____ DOB: _____

Address (street, city, postal code): _____

The purpose of this form is to obtain information about your child to assist with our assessment and consultation. Your signature grants us permission to request or receive information from other service providers.

I hereby authorize the release of information from the following community services to Dr. Ryan Chan

Signature of Legal Guardian_____ Date _____

Telephone: _____

Please complete:

Community Service	Contact Name	Agency/City/Tel	Email Address
Family Doctor			
Pediatrician			
Psychiatrist			
Other physician Specify:			
Mental Health Unit			

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Community Service	Contact Name	Agency/City/Tel	Email Address
Foster Parent			
Infant Development			
Speech and Language Pathologist			
Occupational Therapist			
Psychologist			
Behavioral Consultant			
Teacher			
Other Teacher			
School Specify:			
Preschool			
Day Care			
Supported Child Development			

Initials _____

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Community Service	Contact Name	Agency/City/Tel	Email Address
Other Specify:			
Other Specify:			
Other Specify:			

Personal information is collected by Dr. Ryan Chan under the authority of the Freedom of Information and Protection of Privacy Act. The information is used by Dr. Ryan Chan and his Team to help us assess your child's needs; determine how well we are meeting families' needs; how we can improve our services; and how we can assure quality of care. For more information about the collecting or sharing of information by Dr. Ryan Chan, contact Dr. Ryan Chan's privacy officer at getclarity@drryanchan.com.

Initials _____