Seedlings Pediatrics

Helping sprouts grow

CONSENT TO RELEASE INFORMATION

The purpose of this form is to share information with other professionals to assist with case planning for your child. Your signature at the bottom will constitute your approval.

Child's name:	Care Card No:
Birthdate:	Telephone:
Address:	
Postal Code:	Email:

I give permission for release of information *to/from* Dr. Laine Racher *to/from* agencies indicated:

Agency	
	Parents
	Foster Parents/Legal Guardians
	Ministry of Children & Family Development/Children & Youth Mental Health
	Physician:
	BC Children & Women Hospital
	School Board/District
	School/Preschool
	Kootenay Family Place
	Health Unit
	Other:

Guardian: ________________________________

Signature: ________________________________ Date: _____________________