AMAR SANGHA COUNSELLING

Amar Sangha, RCSW #03228 | RCC #15358

Delta, BC | 604-842-7340 | amar_sangha@hotmail.com | www.amarsanghacounselling.com

CONSENT TO RELEASE CLINICAL RECORDS AND PERSONAL INFORMATION

Use this form for one specific authorization to disclose client information. Complete all relevant sections. Information will be limited to what is authorized below and to what is reasonably necessary for the stated purpose.

Important: This form is for routine client-authorized disclosure only. Legal demands or statutory reporting duties may require a different process.

1. Client Information

Client full name	
Date of birth	
Phone	
Email	

2. Person or Organization Receiving the Information

Recipient / organization	
Contact person / title	
Mailing address	
Phone / fax	
Email	

Purpose of disclosure:

- ☐ Coordination or continuity of care
- ☐ Insurance or benefits
- ☐ Legal matter
- ☐ Employment or disability matter
- ☐ Client personal request
- ☐ Other

How the recipient plans to use the information:

Recipient may further disclose the information without additional client consent, if known: ☐ No ☐ Yes ☐ Unknown

Details:

3. Information Authorized for Release

- ☐ Attendance and appointment dates
- ☐ Treatment or counselling summary
- ☐ Intake or assessment information
- ☐ Goals or treatment plan
- ☐ Progress or session notes
- ☐ Correspondence and referrals
- ☐ Reports or letters
- ☐ Billing / payment / insurance information
- ☐ Entire clinical record
- ☐ Specific document(s)
- ☐ Other

Date range of records: From **To**

Special limits, exclusions, or instructions:

4. Preferred Method of Disclosure

- ☐ Email
- ☐ Fax
- ☐ Mail
- ☐ Client pick-up
- ☐ Other

Verified destination email, fax, or address:

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5. Client Understanding and Authorization

By signing below, I confirm that I understand and agree to the following:

- ☐ I voluntarily authorize Amar Sangha, RCSW, RCC, to disclose the information identified in this form to the person or organization named above for the stated purpose.
- ☐ I understand that I may refuse to authorize a disclosure or may limit the information disclosed. Refusing or limiting consent may affect a service, benefit, assessment, or third-party process that depends on the requested information.
- ☐ I may revoke this consent at any time by notifying Amar Sangha verbally or in writing. Revocation will be documented and will apply going forward. It will not undo information already disclosed in reliance on this authorization.
- ☐ This authorization is valid only until the expiry date written below. A new authorization is required after expiry or for a materially different recipient, purpose, or disclosure.
- ☐ I understand that once information is received by a third party, its further use or disclosure may be governed by that recipient's legal, professional, contractual, or privacy obligations and may no longer be under Amar Sangha's control.
- ☐ I understand that records may be redacted, limited, or withheld where required or authorized by law or professional obligations, including where another person's confidential information is contained in the record.
- ☐ I understand that some disclosures may be made without my consent when required or authorized by law, including applicable child protection duties, prevention of serious harm, or a valid court or legal requirement. Only information that is reasonably necessary will be disclosed in those circumstances.
- ☐ If the record contains information about more than one client, including a couple, family, or group, authorization from each affected client may be required before that client's information can be released.
- ☐ I have had an opportunity to ask questions about this authorization and its possible consequences, and my questions have been answered to my satisfaction.

Expiry date of consent: _____ *Required. Use YYYY / MM / DD.*

6. Client Signature

Client name	
Client signature	
Date / time signed	

If signed by a legal representative:

Representative name	
Relationship / authority	
Signature and date	

Additional client authorization for a joint record, if applicable:

Additional client name	
Signature and date	

If more than two clients are affected, obtain authorization from each affected client on an additional form or attachment.

7. Practitioner Documentation

Reviewed by	
Practitioner signature	
Date reviewed	
Date information released	
Method used	☐ Email ☐ Fax ☐ Mail ☐ Pick-up ☐ Other _____
Information released	

Professional standards note: This form is structured to support BCCSW requirements for written authorization, specified information, identified recipient, stated purpose and use, consent validity, revocation, and joint records, together with BCACC Standards of Clinical Practice concerning client-centred consent, privacy, confidentiality, secure disclosure, and record keeping. Professional judgement and applicable privacy law continue to govern each disclosure.