McGill

Department of Educational and Counselling Psychology
Psycheducational and Counselling Clinic

Authorization to Release Confidential Information

Client Name:_____ **Client Code:**_____

Trainee Name:_____ **Trainee McGill ID:**_____

I _____ (PLEASE PRINT; Last name, First name of Parent/Guardian) authorize

_____ (PLEASE PRINT; Last name, First name of Trainee) of the McGill Psychoeducational and Counselling Clinic to release information to the following parties:

Name of Individual/Agency:_____

Address: _____

_____

_____

Specific information to be disclosed:_____

_____

Name of child if applicable: _____

☐ In keeping with the Regulation I request that the information not be sent prior to 15 days. I may withdraw my authorization any time during this 15 day period.

☐ I waive my right to the 15 day delay and request that this information be sent immediately.

Signature of Client or Parent/Guardian: _____ **Date:** _____

Signature of Course Instructor: _____ **Date:** _____

Trainee Signature: _____ **Date:** _____

*This authorization will expire automatically after 60 days from the date on which it is signed.