The Behavioural Health Foundation Inc.
Box 250, 35 ave de la Digue, St. Norbert, MB R3V 1L6

CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I, _____ hereby give my consent to the Behavioural Health Foundation staff to obtain and release information to all health care providers involved in my care including pharmacists, mental health specialists, primary care physicians, and other health care workers that could facilitate continuity of care while at Behavioural Health Foundation.

I also consent to the following information to be obtained by Behavioural Health Foundation should it be necessary throughout my stay:

- Medication summary
- Medical and psychiatric history
- Medical and psychiatric consultation reports and/or discharge reports
- Other (please specify) _____

My signature means that:

- I have read this consent and I understand and agree with its contents.
- I have been informed that I may revoke this consent by a written statement at any time.
- This consent will expire 72 hours from my discharge from the program.

_____ _____
(Signature) (Date)

October 2019