Consent to Release Information

Developmental Services Ontario
Your access point for adult developmental services
South West Region

I, _____ hereby consent to the two-way sharing of information
(Name)

between Developmental Services Ontario – South West Region and the following individual or organization:

_____

With respect to (select at least one):

☐ Myself

Name: _____ Date of Birth: _____

☐ An adult with a developmental disability

Name: _____ Date of Birth: _____

For the purpose of (select at least one)

☐ Confirmation of Eligibility ☐ Service Navigation

☐ Other (please specify) _____

Description of the information to be shared (select at least one):

☐ Any pertinent information

☐ Specifically the following information:

_____

_____

_____

This consent is valid for the following period: (select one)

☐ One year from date of signature
☐ Other (specify length of time from date of signature) _____
☐ Until revoked by me in writing

I understand that I may revoke this consent in writing at any time.

_____ _____ _____
Signature **Relationship (if applicable)** **Date**

11/12/2017