Authorization to Release/Exchange Confidential Information In order to protect your right to confidentiality, your written authorization is required if you request information to be released to another person or agency. This form cannot be used for the re-release of confidential information. Such requests should be referred to the original individual or agency. authorize _Drs. Beckford or Dr. Dhadwar and other appropriate clinical staff members of the Beeton Medical Clinic to: release to O obtain from achange with Patient's initial (enter third pary) the following information pertaining to myself: Client's initial Client's initial ☐ telephone logs ☐ clinical notes ☐ fax refill requests for medications ☐ laboratory tests ☐ Therapy notes ☐ consultation notes psychiatric evaluations ☐ patient summary O other __ for the purpose of: evaluation/assessment and/or coordinating treatment efforts O other (specify) _ This consent will automatically expire one (1) year after the date of my signature as it appears below. I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time by giving written notice (except to the extent that the information has already been released). Date Signature of Staff Member Signature of Client Date Date of Birth

Beeton Medical Clinic Phone: (905) 729-4888, Fax: (855) 386-2608