Consent to Release and Exchange of Information

I hereby request and authorize (Please include full name/organization, e-mail or fax)

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To release and exchange the following information concerning the student listed below:

Psychological ☐ ____________________ Speech/Language ☐ ____________________

Psychiatric ☐ ______________________ Occupational Therapy ☐ ________________

Medical ☐ _________________________ Audiology ☐ ___________________________

Educational ☐ _____________________ Optometry/Ophthalmology ☐ ___________

All other pertinent diagnostic info ☐ ____

Student's Name: ________________________

Date of Birth: ____________________________

School: ____

Forward to:

Complementary Services Department
Western Quebec School Board
15 Katimavik St., Gatineau, Québec J9J 0E9
complementaryservices@wqsb.qc.ca
Phone: 819-684-2336 ext. 560006
Confidential Fax: 819-684-5800

Signature: ____

Relationship to Student: ____________________________________

Witness: ____

Date: ____