Release of Information Form

The Breathing Space Therapy
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This form allows you to authorize The Breathing Space Therapy to exchange information with another individual or organization for the purpose of supporting your care. All disclosures comply with the Personal Health Information Protection Act (PHIPA) and College of Registered Psychotherapists of Ontario (CRPO) standards.

Client Information

Client Name:	_____
Date of Birth:	_____
Phone/Email:	_____

Recipient of Information

Please specify the individual, agency, or organization authorized to receive or share information:

Name/Agency:	_____
Address/Email:	_____
Phone/Fax:	_____

Purpose of Disclosure

■ Coordination of care ■ Assessment/Diagnosis ■ Legal/Administrative ■ Other: _____

Type of Information to be Released

■ Clinical notes ■ Treatment summary ■ Assessment results ■ Attendance confirmation ■ Other: _____

Duration and Revocation

This authorization will remain valid for one year from the date of signing unless otherwise specified. You may revoke this consent at any time in writing. Revocation will not affect disclosures made prior to its receipt.

Confidentiality and Digital Security

We make every effort to protect your personal health information using secure, encrypted electronic systems. However, no electronic communication can be guaranteed to be entirely secure. By signing below, you acknowledge and accept the potential risks associated with electronic data transmission.

Consent and Signature

I authorize The Breathing Space Therapy and the above-named recipient to exchange information as outlined. I have read and understood the purpose, scope, and duration of this release.

Client Signature:	_____	Date:	_____
Witness (if applicable):	_____	Therapist Signature:	_____