Dr. Robert J. McInerney & Associates
Psychological and Neuropsychological Services Ltd

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Halifax, Nova Scotia B3L 4G4
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Authorization For Release of Personal Health Information (Children and Adolescents)

Name of Child: _____ Date of Birth: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Personal Health Information To Release:

- ☐ Assessment reports
- ☐ Discussion of assessment results, mental health, behaviour, and/or other information pertinent to my child's healthcare (e.g., via phone, videoconference, or in-person)
- ☐ Other (specify): _____

This Information Is To Be Released To:

Name of Person or Organization: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Email: _____

☐ By secure email (no charge) ☐ By fax (no charge) ☐ By regular mail ($15 fee applies)

Authorization

In my capacity as the parent or legal guardian of the child named above, I hereby authorize and request the release of the personal health information indicated above from my child's health record at Dr. Robert J. McInerney and Associates Limited.

_____
Name of parent or legal guardian (please print)

_____ _____
Signature of parent or legal guardian Date