EARLY INTERVENTION THERAPY SERVICES
Kiwanis Hilton Children's Centre
4325 Neill Street
Port Alberni, B.C. V9Y 1E5
Fax: 250-723-7349

Phone: 250-723-1117 **Phone: 250-723-1118**

CONSENT TO OBTAIN AND RELEASE INFORMATION

I, the undersigned parent/legal guardian of _____,
(Date of Birth) _____, do hereby authorize:

☐ Speech-Language Pathology (Island Health)

☐ Occupational Therapy (Outreach Therapy)

☐ Physiotherapy (Outreach Therapy)

to obtain and/or release verbal and written information with the following:

(please initial each column as appropriate)

OBTAIN	RELEASE	AGENCY (provide contact name)	DATE
		Parents by ( )Address ( )Telephone ( )Email ( )Facebook	
		Ministry of Children and Family Development	
		USMA Family & Child Services	
		Foster Parents by ( )Address ( )Telephone ( )Email ( )Facebook	
		Early Years Outreach Program (Nuu-chah-nulth)	
		Infant Development Program (PAACL)	
		Supported Child Development Program (PAACL)	
		Family Physician	
		Paediatrician	
		Other Doctors:	
		Daycare/Preschool Program	
		School District 70	
		Audiology	
		Orthotist	
		Public Health Nursing (Island Health)	
		Public Health Nursing (NTC)	
		First Nations Education Steering Committee	
		Family Support Services (Island Health)	
		Family Support Services (Friendship Centre)	
		Early Childhood Mental Health	
		Other:	

_____ _____
Name of Parent / Legal Guardian (please print) Relationship to Child

_____ _____
Signature of Parent / Legal Guardian Date

_____ _____
Name of Witness (please print) Signature of Witness

Note: This consent expires in one year, upon discharge from service or if guardianship changes.