



CANADIAN MENTAL
HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE
Toronto Branch

CONSENT TO DISCLOSURE and COLLECTION OF PERSONAL HEALTH INFORMATION

I, _____ D.O.B. _____
(Name)
of _____
(Address)

authorize the disclosure and collection of personal health and mental health information
between

_____ and
(Name of person / agency disclosing information)

Canadian Mental Health Association Toronto Branch

(Name of person / agency requesting information)

With regards to _____
(Name) (Address)

All information obtained will be kept confidential between the parties specified above.

I understand I may withdraw this authorization at any time in writing. This release will
be effective for 12 months from the date it is signed.

Signature of Person

Signature of Witness

Please Print Name

Please Print Name

Date