



Name

[Redacted]

Facility

H.R.C.

Casebook No.

[Redacted]

Ward or Unit

C0710

You are hereby authorized to release to/or obtain from

YORK SUPPORT SERVICES

Name of facility, agency, physician, etc.

NETWORK

any information from my records, in accordance with the policy of the facility, as may be necessary or desirable for my care or treatment.

Date

APRIL 7/97

Date

Witness

[Redacted]

Signature of Resident

[Redacted]

Address of Witness

Social Home H.R.C.

Relationship - If other than Resident

[Redacted]

AUTHORIZATION RECEIVED BY TELEPHONE
FROM [Redacted] (SISTER) ON APRIL 7/97
[Redacted] U.S.A.

* AUTHORIZATION must be signed by the resident, or in the case of a minor by the parent or legal guardian whichever is the appropriate legal authority. In the case of a person who is physically or mentally disabled to such a degree as to be incapable to give consent, the next-of-kin may authorize release of information.

CONSENT FORM

I, [redacted] (parent/guardian name), give consent to YORK SUPPORT SERVICES NETWORK (agency name) to provide information to the Ministry of Community and Social Services regarding [redacted] (name of individual in residential care) for the Levels of Support Project.

I understand that this information is being collected using a client identifier code and that the information gathered is to be used for research purposes to measure the care provided to children and youth receiving residential care.

Signature _____ (parent/guardian)

Witness [redacted] (not agency staff)

Date H.R.C. Social Worker
June 17/97.

CONSENT RECEIVED JUNE 17 1997 BY
THERESA FROM [redacted]
(SISTER).

[redacted]
Social Work Services