



Consent to the Release of Information

Client _____

Date of Birth (mm/dd/yyyy) _____

I hereby authorize the representatives of Angus Lloyd Associates Inc. to obtain and disclose academic, medical, vocational and other records and documentation pertinent to my rehabilitation program. A copy of this consent may be used.

Obtain from/Disclose to:

Type of release

Verbal Exchange
Documentation
Facsimile
Electronic

Additional Comments

I hereby provide my permission for Angus Lloyd Associates Inc. to release and disclose obtained information with the institutions or individuals directly involved in my rehabilitation program. I understand that my information will be kept private in accordance with PIPEDA guidelines, and that I may change or cancel the above authorization in writing at any time prior to the expiry date, unless action has already been taken on the basis of authorization.

Signed: _____

Date: _____

Witness: _____

Date: _____

Expiry: _____

ANGUS LLOYD ASSOCIATES INC.
8 Lawton Blvd.
Toronto, ON M4V 1Z4
T: 416 944 8185