Saskatchewan Health Authority

Autism Spectrum Disorder Department
1000B Albert Street
Moose Jaw, SK S6J 2Y2
P: 306-691-2308 | F: 306-691-2333

Moose Jaw Autism Spectrum Disorder Program

CONSENT FOR EXCHANGE OF INFORMATION

I, _____, (client/parent/guardian) hereby authorize Moose Jaw Autism Spectrum Disorders Program, to exchange information , either verbally or in hard copy, as required relating to interviews, tests and procedures pertaining to _____ with the following:

Exchange of Information with: (complete where exchange of Information is Required)	**Name of Provider (if applicable)**	**Additional Date of Consent Day/Month/Year**	**Initial**
Audiologist			
Day Care (Specify)			
Early Childhood Intervention Program			
Early Learning and Child Care Consultant			
Family Physician/Nurse Practitioner			
Pediatrician			
Mental Health and Addictions			
Occupational Therapist			
Physical Therapist			
Psychologist			
Public Health Nurse			
School Professionals			
✓ School Division (specify)			
✓ Teacher			
✓ Teacher Assistant			
✓ Student Support Teacher			

Exchange of Information with: (complete where exchange of Information is Required)	Name of Provider (if applicable)	Additional Date of Consent Day/Month/Year	Initial
Speech/Language Pathologist			
Wascana Rehabilitation Centre, Regina			
Family Resource Centre Professional			
Community/Other Agency			
✓ KidsFirst			
✓ Social Worker			
✓ Family Resource Centre Professionals			
✓ Recreation Program Staff			
✓ Spiritual Program Staff			
✓ RCMP/City Police			
Ministry of Justice, Community Corrections			
Ministry of Social Services			
Other:			

☐ **Interpretation Services used to complete form.**

I would like the following restrictions to apply:

I understand that the information will be used for the purposes of assessment and treatment of my child. I am aware that I may cancel my consent at any time. This authorization is given at _____, Saskatchewan this _____day of _____, 2 _____ ending the _____day of _____, 2_____.

_____ _____

Signature of client/parent/guardian Relationship

_____

Witness to Signature