Tele-Mental Health Services,
provided by

SickKids®

CPRI
Child and Parent
Resource Institute

CHEO

LAST NAME	(FIRST)
MRN	VISIT NUMBER
DATE OF BIRTH YYYY-MM-DD	SEX
ADDRESS	

IMPRINT OR ENTER DETAILS BY HAND

Consent to Release of Information for Program Consultation Purposes

Part one

Dear: _____
Parent or Guardian

_____ _____
Name of Client Client's Date of Birth (YYYY-MM-DD)

Will be receiving service from the:

_____
Name of Agency Program

To better support staff in this program, we may schedule consultations with other clinical consultants from the Tele-Mental Health Services. During these program consultations issues relating to your child may come up and we would like your written permission to discuss them with our consultant(s) in Tele-Mental Health Services. All information is treated confidentially and there will not be a written report about your child.

Part two if applicable ☐

We feel it is also important to let your family doctor or paediatrician know that we may be talking to a consultant about your child as part of the above mentioned agency program.

We would like to send a copy of this letter to your child's physician and ask that you sign this consent form in order for us to do this.

If you have any questions, please speak with your case manager.
Thank you for your cooperation.

Yours truly,

_____
Per: D. Willis (Hub staff), Program Manager

Cc. _____ ☐ If applicable
Attending physician

_____ _____
Parent/Guardian signature Date (YYYY-MM-DD)

Hub site use only

Copy to parent/guardian:_____ copy to physician:_____ copy to file:_____
Date (YYYY-MM-DD) Date (YYYY-MM-DD) Date (YYYY-MM-DD)