PEACE
OF MIND
COUNSELLING & THERAPY

CONFIDENTIAL CLIENT INTAKE INFORMATION

I _____ give my permission for **Peace of Mind Counselling & Therapy** to share my information with the listed 'checked' service providers in support of my wellbeing.

Statement of Consent:

I agree that personal information about me may be shared with the following agencies:

- Alberta Health Services
- Victim Services including the police
- Education Support Services
- North Peace Housing
- Other (please specify) ----------

☐ I agree to my information being shared between services.

Your consent to share personal information is entirely voluntary and you may withdraw your consent at any time. Should you have any questions about this process or wish to withdraw your consent please alert me to this and text or email me at: 780 205-5682 or alix@peacemind.ca .

Name …… Signature ………

Date ……

Therapist Signature ……

Therapist printed name: Alix McLauchlan MSW, RSW, BEd