Community Dental
ACCESS CENTRE

CONSENT FOR RELEASE/EXCHANGE OF INFORMATION

Client's Name: _____**Birth date:** _____

BC Care Card #_____

Family Doctor: _____ **Walk-in Clinic you attend:** _____

Please complete for the agencies that you have visited.

- ❒ **Gateway Shelter:** worker's name and contact #_____
- ❒ **Upper Room Mission:** Outreach Worker's name and contact #_____
- ❒ **Interior Health Mental Health and Addictions:** support worker's name and contact #_____
- ❒ **Ministry of Social Development:** financial worker's name and contact # _____
- ❒ **Howard House:** worker's name and contact #_____
- ❒ **Employment Program:** worker's name and contact #_____
  (i.e. Community Futures, North Okanagan Employment & Enhancement Society etc.)
- ❒ **North Okanagan Youth and Family Services:** (NOYFSS) worker's name and contact # _____
- ❒ **Social Worker:** name and contact #_____
- ❒ **Immigration Services** worker's name and contact _____
- ❒ **Women's Transition House:** workers name and contact _____
- ❒ **Seniors Bureau:** workers name and contact #_____

Other _____worker's name and contact #_____

I consent to release and exchange of information between my physician and/or medical clinic, government, pharmacist and/or social agencies and the Community Dental Access Centre staff to facilitate my dental care. Agencies may help to remind me of my dental appointments.

This information is subject to the Freedom of Information and Protection of Privacy Act.

This release of information will be in effect until I request a change.

Client's Signature _____ **Date** _____