COMMISSION SCOLAIRE WESTERN QUÉBEC SCHOOL BOARD

Consent to Release and Exchange of Information

I hereby request and authorize (Please include full name/organization, e-mail or fax)

_____

_____

_____

_____

To release and exchange the following information concerning the student listed below:

Psychological ☐ _____ **Speech/Language** ☐ _____

Psychiatric ☐ _____ **Occupational Therapy** ☐ _____

Medical ☐ _____ **Audiology** ☐ _____

Educational ☐ _____ **Optometry/Ophthalmology** ☐ _____

All other pertinent diagnostic info ☐ _____

Student's Name: _____

Date of Birth: _____

School: _____

Forward to:

Complementary Services Department
Western Quebec School Board
15 Katimavik St., Gatineau, Québec J9J 0E9
complementaryservices@wqsb.qc.ca
Phone: 819-684-2336 ext. 560006
Confidential Fax: 819-684-5800

Signature: _____

Relationship to Student: _____

Witness: _____

Date: _____