



Destiny

RECOVERY & WELLNESS CENTRE

Rooted In Land and Spirit

CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I, _____ hereby give my consent to Destiny Recovery And Wellness Centre to obtain and release information to all health care providers involved in my care including pharmacists, mental health specialists, primary care physicians, and other health care workers that could facilitate continuity of care while at DRAWC.

I also consent to the following information to be obtained by DRAWC should it be necessary throughout my stay:

- Σ Medication summary
- Σ Medical and psychiatric history
- Σ Medical and psychiatric consultation reports and/or discharge reports
- Σ Other (please specify) _____

My signature means that:

- I have read this consent and I understand and agree with its contents.
- I have been informed that I may revoke this consent by a written statement at any time.
- This consent will expire 72 hours from my discharge from the program.

(Signature)

(Date)

CONTACT US

☎ Phone: 1-877-250-HOPE

✉ Email: info@destinywellness.ca

☎ Fax: 1-431-815-4898