Stoney Creek Counselling

Where compassionate support meets professional expertise

Candice Babbey, M.S.W., R.S.W.
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Consent to Disclose Personal Health Information

I, _____ (date of birth: _____) give permission for Stoney Creek

Counselling to share my clinical notes with:

_____

Name Business / Institution Address

_____

Telephone Number

For the purpose of:

_____
_____
_____.

This consent is valid for a 3-month period from the date of signature.

Signature (client): _____ Date: _____

Signature (Witness): _____ Date: _____

Stoney Creek Counselling
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