



Child/Youth Information

Last name: _____

First name: _____

Date of Birth*: _____

Address: _____ Apt./Unit #: _____

City: _____ Province: _____ Postal Code: _____

Phone (home): _____ Phone (cell): _____

** If child is 12 years of age or older, child/youth must authorize request by signing below*

Parent/Legal Guardian (substitute decision-maker) Information**

Last name: _____

First name: _____

Address: _____ Apt./Unit #: _____

City: _____ Province: _____ Postal Code: _____

Phone (home): _____ Phone (cell): _____

*** You may be asked to provide documentation that demonstrates that you are the authorized substitute decision-maker*

Type of Information requested:

- Intake Information
- Reports prepared by EveryMind (e.g., assessments, treatment plans, psychiatric & psychological reports, service summaries)
- Reports contained in the EveryMind Record received from external sources
- Other Information (please specify): _____

Preferred method of access to records: Examine Original Receive a Copy

Child/Youth Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Please complete this form and fax to Clinical Records 905-696-0350 **OR**
mail to EveryMind Clinical Records, 85A Aventura Court, Mississauga ON L5T 2Y6
For more information call Clinical Records 905-795-3500 ext. 2323

For office use only:

File #: _____

Date request received: _____ Date manager notified: _____

Outcome of request, including request release date: _____
