APPENDIX C – Consent for Release of Information to Agency

I _____ (Parent/legal guardian), of the child (full name) _____ date of Birth _____ consent and authorizes the Department of Education and Early Childhood Development of the Province of New Brunswick to share / disclose the following personal information, personal information on health, documents, forms and / or reports about my child (name of child) with the agency AIS.

Please check boxes bellow to receive/share information, documents and reports of:

- ☐ Child name
- ☐ Date of birth
- ☐ Diagnosis confirmation form
- ☐ Language of service
- ☐ Language of communication with the parents
- ☐ Parents address, phone number, and email

I am the parent or legal guardian of the child (full name) _____ to which the requested information applies. I declare that I have examined the information on this form, and accompanying documents, and it is true and correct to the best of my knowledge. I also understand that I can revoke this consent at any time by providing written notice to the Department of Education and Early Childhood Development. My signature below indicates my consent.

_____ _____

Parent/legal guardian signature Date

_____ _____

Witness signature Date

The above information will be used in compliance with the New Brunswick Right to Information and Protection of Privacy Act.

Please send completed and signed forms to autism.autisme@gnb.ca or fax to 506-462-2104 or mail to:

Education and Early Childhood Development
Preschool Autism Program
Place 2000, 250 King Street
Fredericton, NB
E3B 9M9