Gya' Wa' Tlaab
Healing Centre Society

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CONTINUUM OF CARE: DECLARATION BY CLIENT

For the purpose of supporting the "Continuum of Care" and to ensure safe prescribing practices, I consent to allow the ATTENDING PHYSICIAN, ATTENDING DENTIST, and the ATTENDING PHARMACIST of the GYA' WA' TLAAB HEALING CENTRE to:

- ☐ contact my primary physician to discuss my medical status
- ☐ access my PharmaNet profile
- ☐ contact NIHB benefits, if applicable.

Furthermore, I assert that:

- ☐ I have been fully informed about this consent issue, and that I voluntarily give my consent to the sharing of this information.
- ☐ I understand that I can revoke my consent at any time.
- ☐ The photocopy of my signature on this form is as valid as the original.

Client Signature:	Date:

CLIENT RELEASE

I, _____, hereby permit the Gya' Wa' Tlaab Healing Centre Society's attending physician to release medical facts and assessments about me to the Gya' Wa' Tlaab Healing Centre Treatment Team for the purpose of continuum of care. The photocopy of my signature on this form is as valid as the original.

Client's Signature:	**Date:**