**Consent to the Collection, Use and Disclosure of Personal Health Information**

Authorization must be signed by the client or by the legally authorized representative

in the case of incompetency or other circumstances.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| I, | Click here to enter text. | | | | | | | | | | | | | hereby authorize the | |
|  | Name of individual receiving service or Substitute Decision Maker/Power of Attorney\* | | | | | | | | | | | | |  | |
| **Collection** | | | | | | | **Use** | | | | | **Disclosure/Release of Information** | | | |
|  | | | | | | |  | | | | |  | | | |
| Of the following information: | | | | | | | | | | Choose an item. | | | | | |
| *If* Other, *or* required, please explain: | | | | | | | | | | Click here to enter text. | | | | | |
|  | | | | | | | | | | | | | | | |
| Compiled at: | | | | CMHA Peel Dufferin | | | | | | *or* | Click here to enter text. | | | | |
|  | | | | | | | | | | | (Name of facility) | | | | |
|  | | | | | | | | | | | | | | | |
| From the record of: | | | | | Click here to enter text. | | | | | | | | | | |
|  | | | | | (Client Name) | | | | | | | | | | |
| Date of Birth: | | | | | Click here to enter text. | | | | | | | | | | |
|  | | | | | (dd/mm/yyyy) | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| *to:* | |  | Canadian Mental Health Association Peel Dufferin | | | | | | | | | | | | |
| *to:* | |  | Specify Name: | | | | | | Click here to enter text. | | | | | | |
|  | |  | Specify Address: | | | | | | Click here to enter text. | | | | | | |
|  | | | | | | | | | | | | | | | |
| ***For the purpose of service provision*** | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| Are there any restrictions associated with this consent? | | | | | | | | | | | | | No  Yes | | |
| *If* yes, please explain: | | | | | | Click here to enter text. | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| **Consent:**  I understand the private and confidential nature of this information and agree that it will be used only for the stated purpose. This authorization will be invalid once services are completed by the releasing agent. I understand that I can withdraw my consent at any time with proper notice. | | | | | | | | | | | | | | | |
| \*Substitute Decision Maker (SDM)/Power of Attorney (POA) documentation provided | | | | | | | | | | | | | | | |
| (please print)  **Name of Client or SDM/POA\*:** | | | | | | | |  | | | | | | | |
| (signature of client or SDM/POA)  **Signature:** | | | | | | | |  | | | | | | | (dd/mm/yyyy)  **Date:** |
| (please print)  **Witness:** | | | | | | | |  | | | | | | | |
| (signature)  **Witness:** | | | | | | | |  | | | | | | | (dd/mm/yyyy)  **Date:** |