**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,  |  | 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:  |
| [ ]  Behavioral Plan Information[ ]  Coordinated Care Plan[ ]  Crisis/Flu Plan[ ]  Developmental Information | [ ]  Discharge Medication[ ]  Discharge Summary[ ]  Initial/Preliminary Assessment[ ]  Medical Information | [ ]  Psychological Information[ ]  Psychiatric Consultation & Assessment Info[ ]  Visit/Contact Notes/Summary[ ]  Other |
| *If* Other, *or* required, please explain: |  |
|  |  |
| Compiled at: | CMHA Peel Dufferin | *or* [ ]  |  |
|  |  |   (Name of facility) |
|  |  |  |
| From the record of: (Client Name)  |  |
| Date of Birth: (dd/mm/yyyy) |  |
|  |  |
| *to:* |[ ]  Canadian Mental Health Association Peel Dufferin |
| *to:* |[ ]  Specify Name: |  |
|  |  | Specify Address: |  |
|  |  |  |  |
| ***For the purpose of service provision*** |
|  |  |
| **Are there any restrictions associated with this consent?** | [ ]  No [ ]  Yes |
| *If* yes, please explain: |  |
|  |  |
|  |  |
|  |  |
| **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:** |