NORTH EAST LHIN

HealthLinks

CONSENT TO COLLECT, USE AND DISCLOSE PERSONAL HEALTH INFORMATION

Please PRINT in all but the signature field.

Name of person receiving services:_____ Date of Birth:_____
(DD/MM/YYYY)

1. I have received a copy of the Health Links Privacy information package and have been given the chance to ask questions.
2. By signing this document, I confirm that I know and understand that:

☐ I choose the members of the Care Team which may include health care organizations, community and social service providers, friends and family members. *Note: Ontario's privacy laws may not apply to the family and friends I have chosen as part of the Care Team.*

☐ Members of the Care Team, including the Health Links Coordinator, will consult me, and each other, as they:
- review personal health information such as diagnoses, assessments, treatments and medications;
- consider what services may be needed (now and in the future); and/or,
- create or update the Coordinated Care Plan (CCP).

☐ The law allows community and health care agencies, even those outside of your chosen Care Team, to collect and share personal health information if they need to do so to provide care. This may include collection from/release to local, regional or provincial repositories of electronic health records containing your personal health information.

☐ Information from the Coordinated Care Plan may be shared with provincial partners and funders for the purpose of evaluating care and related services.

☐ I can speak to the Lead Care Coordinator to:
- Ask questions, or make a complaint, about how my personal health information is handled and shared;
- Make changes to the Care Team;
- Give or withdraw my consent related to access to my personal health information; or,
- Ask for a copy of, or correction to, the Coordinated Care Plan.

☐ I may refuse to sign this consent form and to do so means that I may not receive the benefits of a Coordinated Care Plan.

Printed Name	Signature	Date (DD/MM/YYYY)

☐ I am the person who will be receiving services.
☐ I am the person who is authorized to make health care decisions for the person who will be receiving services.

Health Link partner who obtained consent: _____

Printed name of person collecting	Signature	Date (DD/MM/YYYY

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Care Team	
Name/Organization	**Relationship**
NE LHIN (eg. Health Links, Home and Community Care)	
Community Hospital(s) (please list)	

Restrictions
I do not wish for those individuals or organizations listed below to have access to personal health information.