ST.AMANT CLINICAL SERVICES
CONSENT FORM

NAME OF INDIVIDUAL:	D.O.B.:

CONSENT FOR EXCHANGE OF INFORMATION:

- Under Section 22(2)(a) of the Personal Health Information Act (PHIA), Province of Manitoba, referring agencies and other services may exchange information without consent for the purpose of assessment, treatment and further referral.
- Under Section 23(1)(a,b,c) of (PHIA), information may be exchanged with the immediate next of kin.
- Other person(s) not authorized under the Act and who wish to receive information or a copy of a report are required to obtain written consent from the individual or the authorized legal representative or legal guardian.
- Please consider key individuals when providing consent for exchange of information or reports, for instance, physicians, case managers, SDM, day programs.
- In situations of abuse, neglect, court order, and/or immediate threat of harm to self or others, disclosure of such information is required by law.

Please assist us by providing the contact information requested below. Note that clinicians may exchange information with other service providers, as permitted by PHIA and professional codes of conduct, who are not listed below, unless instructed otherwise.

The following are the list of individuals with whom I understand information may be exchanged:

NAME	TITLE	AGENCY	ADDRESS / POSTAL CODE	PHONE #	EMAIL

- I understand that the information collected and exchanged will be used for the purposes of assessment, planning, developing programs and/or strategies that will benefit the individual or family understand the risks and benefits of consenting or refusing to consent. Information or reports of a statistical nature may be shared with the funder for accountability, funding or research purposes.
- This consent is valid for the duration of program participation unless otherwise specified by the consenter.
- The consenter is asked to provide updated contact information as appropriate.

RELATIONSHIP OF SIGNING AUTHORITY

ADULTS:

☐ **SDM:** ☐ **Personal** ☐ **Financial** ☐ Joint ☐ Alternate

☐ **COMMITTEE:**

☐ **SELF:**

☐ **OTHER (Specify):**

CHILDREN:

☐ **PARENT(S):** ☐ **Joint Custody** ☐ **Sole Custody**

In the case of joint custody, both parents' signatures are required.
In the case of sole custody, documentation must be provided as evidence of such agreement. Only the signature of the parent with legal decision making power is required.

☐ **CFS:**

☐ **OTHER (Specify):**

Signature(s) of Individual/Legal Representative/Guardian Date

Print Name(s) of Individual/Legal Representative/Guardian

Signature(s) of Joint Representative(s) (if applicable) Date

Print Name(s) of Joint Representative(s) (if applicable)

Signature of Witness Date

CLINICAL SERVICES OFFICE USE ONLY: