

Client Name: \_\_\_\_\_

**NOTE TO CLIENT:** *We want your informed consent. This means we want you to understand the services we hope to provide to you and what we do with the personal information we obtain about you. We work to provide you with health care services that meet your needs and enable you to seek those services at organizations across the province. In doing so we may need to share your personal health information via fax or an electronic sharing system with other health service providers who are involved in your care.*

- ✓ I understand that I may access services at CMHA Windsor Essex County Branch and/or the CMHA Health Care. The type and extent of services, available options for services, and the risks and benefits of services have been explained to me. I have had the opportunity to ask questions about the services provided.
- ✓ I understand that I have specific rights and responsibilities related to my care. If I choose to participate in ongoing service I understand I will receive additional information about programs, services, privacy and safety.
- ✓ I understand that the agency will collect, use and disclose my personal health information for the purposes of referral, consultation, assessment and provision of services.
- ✓ If CMHA-WECB staff believe that I am a risk to harm myself, others, or suspect child abuse, by law they are required to report this
- ✓ I understand that an electronic sharing system is used to share my assessment data and/or prescription drug information history with other health service providers, who may need to review the data in order to provide services to me. I understand I may withdraw consent to sharing my assessment and/or prescription drug information in the electronic sharing system at any time.
- ✓ I also understand that this personal health information may be used and electronically shared with other individuals and service providers such as doctors, nurses, care givers, community care providers and other organizations involved in my care in order to provide the most comprehensive services possible.
- ✓ I understand that my use of services and my personal health information will remain secure and confidential. Disclosure of information to others outside those involved in my care will only be made with my consent. I further understand that there are specific exceptions to this confidentiality as explained to me.
- ✓ I agree that the information was provided to me in simple, easy to understand language and addressed my cultural beliefs and preferences.
- ✓ I understand that I will receive a copy of this signed consent form.
- ✓ I understand that CMHA Windsor Essex County Branch facilities are monitored for the safety of clients and staff and my image may be captured for this purpose. For more information, please contact facilities and corporate services (519) 255-7440.
- ✓ I declare I have read, understood and agree to the contents of this Informed Consent Agreement in its entirety. By signing this form, I confirm I understand the purpose for which my personal health information is collected, used and shared and my privacy rights.

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_  
(Client, Guardian or Substitute Decision-Maker if applicable) MM/DD/YYYY

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Client, Guardian or Substitute Decision-Maker if applicable) MM/DD/YYYY File:  Recorded in CRMS   
 Copy to client

***This consent is valid for twelve (12) months from the date signed by the client. Please refer to the brochures provided or ask your assigned worker for additional information regarding the collection, use and disclosure of your personal health information.***  
*Review with Client Required Every 12 Months*

**Specific Consent – Collection or Release of Information to Individuals or Organizations Outside the “Circle of Care”**

I (name in full) \_\_\_\_\_ (date of birth) \_\_\_\_\_  
of (address) \_\_\_\_\_

Hereby consent to obtain/release information between  
CMHA-WECB  
-AND-

\_\_\_\_\_ (name of organization or individual) the  
following information (provided a list of specific information being requested or released).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Client, Guardian or Substitute Decision-Maker if applicable) MM/DD/YYYY

***This specific consent is valid for twelve (12) months from the date signed.***

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**Withdrawal of Consent or Consent Directives**

I, \_\_\_\_\_ wish to withdraw my consent to any further use, or disclosure by CMHA-WECB/CCHC of my (son/daughter/ward) personal health information as described below or wish to place the noted conditions (consent directives) on any further use or disclosure of my (son/daughter/ward) personal health information.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Tel. Home: \_\_\_\_\_ Tel. Work: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Client, Guardian or Substitute Decision-Maker if applicable) MM/DD/YYYY

***Note to Worker:***

- A. ***If the client withdraws consent or has requested special conditions be placed on the collection, use or disclosure of their personal health information and/or OCAN assessment data please document in the client file and notify the Chief Privacy Officer.***
- B. ***If the client withdraws or partially withdraws consent to share prescription drug information the client must complete and submit a Withdrawal of Consent Form to the MOHLTC.***