TRAVERSE INDEPENDENCE

CONSENT TO COLLECT AND DISCLOSE PERSONAL HEALTH INFORMATION

Privacy: As a provider of health care services, Traverse Independence collects, uses, discloses, retains and protects personal information about you. As an agency we are committed to protecting the privacy, confidentiality, and security of all personal information that is entrusted to us. Traverse Independence is considered to be a personal health information custodian under the Ontario Personal Health Information Protection Act, 2004. (See attached Privacy Notice for complete details).

Research: Traverse Independence pursues ongoing relationships with academic and research facilities. I understand that information may be gathered from my health record for research purposes, but confidentiality will be respected with no information disclosing my identity being released or published. By signing below, I acknowledge any questions have been answered to my satisfaction, and I have been informed I may refuse release of my records at any time without compromising the quality of care received from Traverse Independence by indicating in the check box below.

☐ By checking this box, I refuse the confidential release of my records to academic and research partnerships of Traverse Independence.

Consent for Personal Health Information:

This form confirms that I, or my Substitute Decision Maker, understand that to provide me with services, Traverse Independence will collect my personal health information. I recognize that I have the opportunity to ask questions about Traverse Independence's privacy policies, and I understand that there are some rare exceptions to the commitment to privacy.

I, _____ Date of Birth _____

hereby agree to the following:

- To allow documentation of a personal health nature to be reviewed by Traverse Independence internal staff for the purpose of administrative responsibilities, risk management, to maintain or improve the quality of care, or for staff education to provide health care, as well to allow Traverse Independence to access patient personal health information through ClinicalConnect Provider e-portal.
- To the sharing and/or exchange of information in the event that sharing is necessary because of an emergency that threatens the health or safety of myself or another individual (this includes with the Emergency Department of a hospital).
- To allow Traverse Independence to collect and use personal health information about me for the purpose of assessment, research, planning, or delivering services.
- To the disclosure to and/or exchange of written, verbal, and/or electronically transmitted information between Traverse Independence and the Waterloo Wellington ABI Support Coordination Clinic at the Kitchener Downtown Community Health Centre, as well as:

☐ By checking this box, I refuse the confidential release of my records to the Waterloo Wellington ABI Support Coordination Clinic at the Kitchener Downtown Community Health Centre.

Any specified restrictions:

The consent expires on the ____ day of ____ year ____

I understand that this consent may be revoked at any time, except for actions that have already been taken.

Signature of Client or Substitute Decision Maker

Signature of Witness

Dated this ____ day of ____ year ____

Or verbal consent received by

On date (mm/dd/yyyy)

____ translated the information on this form and verified the client's responses.

A photocopy of this authorization shall have the same validity as the original.