MUSHKEGOWUK COUNCIL

MUSHKEGOWUK HEALTH

Consent to the Collection, Use and Disclosure of Personal Health Information

I, ________________________________, have reviewed Mushkegowuk Health's privacy notice concerning the collection, use and disclosure of personal health information ("Client/Patient Privacy Notice" pamphlet).

- I understand that Mushkegowuk Health is seeking my consent to collect, use and/or disclose my personal health information (or the personal health information of the person on whose behalf I am acting as a substitute decision-maker) for the purposes listed in the Client/Patient Privacy Notice.
- I understand that Mushkegowuk Health will only collect, use and disclose my personal health information (or the personal health information of the person on whose behalf I am acting as a substitute decision-maker) with my consent as set out in the Privacy Notice, unless a particular collection, use or disclosure is permitted or required by law without my consent.
- I also understand that I can refuse to sign this consent form. I can also withdraw consent at any time by writing to Mushkegowuk Health.

I hereby authorize Mushkegowuk Health to collect, use and disclose my personal health information (or the personal health information of the client for whom I am the substitute decision-maker) for the purposes mentioned above.

Client's Name: ____

Date of Birth: ____

____________________________________ Date: __________________

Client or substitute decision-maker signature

____________________________________ Date: __________________

Staff signature (I have reviewed the above information with the client or his/her substitute decision-maker)