



LAST NAME	(FIRST)
MRN	VISIT NUMBER
DATE OF BIRTH DD-MM-YYYY	SEX
ADDRESS	
IMPRINT OR ENTER DETAILS BY HAND	

### Consent to the Disclosure of Personal Health Information – Tele-Mental

Agency client #: \_\_\_\_\_ MRN: \_\_\_\_\_

I, \_\_\_\_\_,  Client  
 \_\_\_\_\_,  Guardian/Substitute decision maker  
Print name (First, Last)

authorize the Tele-Mental Health Service to disclose the personal health information of \_\_\_\_\_ consisting of a **Tele-Mental Health Consultation Report**  
Client name (First, Last)

to the following:

1. \_\_\_\_\_ Fax #: \_\_\_\_\_  
Name of referring agency requesting information

2. \_\_\_\_\_ Fax #: \_\_\_\_\_  
Name of primary care provider requesting information

I, \_\_\_\_\_,  Client  
 \_\_\_\_\_,  Guardian/Substitute decision maker  
Print name (First, Last)

authorize the Tele-Mental Health Coordinating Agency & \_\_\_\_\_  
Name of referring agency disclosing information

to disclose the personal health information of \_\_\_\_\_  
Client name (First, Last)

to the Tele-Mental Health Service. **I consent to the following information to be disclosed:**

Consultation reports     Medical history     Medication summary

Other: \_\_\_\_\_

I agree to be contacted to learn more about research opportunities I / my child may wish to participate in. I am aware that declining to participate in teaching and / or any research-related activities will not have any impact on any services I / my child will receive through Tele-Mental Health Services.

#### NOTICE OF COLLECTION

Information collected through Tele-Mental Health Services will be entered into a data system used to process and schedule appointments, for quality improvement, for approved research studied that do not require information identifying the patient, and for other purposes permitted or required by law. This includes disclosure of personal health information to The Institute for Clinical Evaluative Sciences (ICES) as a prescribed entity for the purposes of section 45 of the Ontario's Personal Health Information Privacy Act. Information collected this way will be pooled with other similar information and no one participating in this consultation will be individually or specifically identified.

REQUIRED	Print name of client	Signature of client	Date DD-MM-YYYY
	Print name of parent / guardian	Signature of parent / guardian	Date DD-MM-YYYY