SickKids®

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 — TeleLink

I, _____, ☐ Client ☐ Guardian/Substitute decision maker
Print name (First, Last)

authorize The Hospital for Sick Children to disclose the personal health information of

_____ consisting of a **TeleLink 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 _____ to disclose the personal health information
Name of referring agency disclosing information

of _____ to The Hospital for Sick Children.
Client name (First, Last)

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 TeleLink Health Services.

NOTICE OF COLLECTION

Information collected through the TeleLink Mental Health Program will be entered into a data system used to process and schedule appointments, for quality improvement, for approved research studies 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