Interlake-Eastern
Regional Health Authority

SERVICE COORDINATION AGREEMENT
FOR RELEASE OF PERSONAL AND/OR PERSONAL HEALTH INFORMATION

SECTION 1: PURPOSE OF THE CONSENT

I consent to sharing of my personal information and/or health information between the agencies indicated below. The purpose of sharing information about me is to allow the service providers from each agency to discuss my situation and develop a complete service plan that will address my health and social service needs.

SECTON 2: CONFIDENTIALITY

I understand the information shared will be on a need to know basis only. It is also my understanding that each of the participating agencies will maintain confidentiality over the information in accordance with standard agency policies, legislation such as *The Freedom of Information and Protection of Privacy Act* (FIPPA) and *The Personal Health Information Act* (PHIA) and other applicable legislation.

SECTION 3: ORGANIZATIONS / AGENCIES INCLUDED IN THE PLANING PROCESS

Please specify organization/agency (e.g. Family Services, Interlake-Eastern Regional Health Authority, or other agency) and program (e.g. Child and Family Services, Community Mental Health Services) within each organization/agency and name of service provider:

Name of Organization/Agency:	**Program:**	**Service Provider:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SECTION 4: EXPIRATION OF CONSENT

This consent shall start on the date that I sign this form and will automatically end one year later. I know that I can withdraw my consent or make changes to it at any time by contacting my lead service coordinator. I also understand that none of the organizations/agencies can share my personal information or personal health information without obtaining another consent from me unless required by law.

SECTION 5: QUESTIONS

Should you have any questions about how your personal information or personal health information is being used, please discuss your concerns with your service provider.

SECTON 6: SIGNATURES

Client _____ _____ DOB _____
LAST NAME FIRST NAME DD/MMM/YYYY

Street Address: _____

City: _____ Postal Code: _____

Client Signature: _____ Date: _____

SECTION 7:
CONSENT ON BEHALF OF SERVICE RECIPIENT IN ACCORDANCE WITH SECTION 60 OF THE PERSONAL HEATH INFORAMATION ACT

I _____
am exercising the rights for the service recipient in accordance with the *Personal Health Information Act,* Section 60.

A by any person with written authorization from the individual to act on the individual's behalf;
B by a proxy appointed by the individual under *The Health Care Directives Act*;
C by a committee appointed for the individual under *The Mental Health Act* if the committee has the power to make health care decisions on the individual's behalf;
D by a substitute decision maker for personal care appointed for the individual under *The Vulnerable Person's Living With A Mental Disability* if the exercise of the right is related to the power and duties of the substitute decision maker;
E by the parent or guardian of an individual who is a minor. Or if the minor does not have the capacity to make health care decisions; or
F if the individual is deceased, by his or her personal representative

CONSENT ON BEHALF OF SERVICE RECIPIENT IN ACCORDANCE WITH THE FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT

I _____
am exercising the rights for the service recipient in accordance with the *Freedom of Information and Protection of Privacy Act,* Section 79.

A by any person with written authorization from the individual to act on the individual's behalf;
B by a committee appointed for the individual under *The Mental Health Act* if the committee has the power to make health care decisions on the individual's behalf;
C by an attorney acting under a power of attorney granted by the individual. If the exercise of the right or power related to the powers and duties conferred by the power of attorney;
D by the parent or guardian of a minor when, in the opinion of the head of the public body concerned, the exercise of the right or power by the parent or guardian would not constitute an unreasonable invasion of the minor's privacy; or
E if the individual is deceased, by the individual's personal representative if the exercise of the power or right relates to the administration of the individual's estate.

Signature of Individual on Behalf of the Service Recipient:

_____

Print Name _____ _____
Last Name First Name

Relationship_____

Date: _____ Telephone #: _____