Consent to Release Personal Health Information

Pursuant to the Child Youth and Family Service Act, Part X (Personal Information), 2017 (C.Y.F.S.A.), I, _____, authorize Bayfield Treatment Centres to receive and disclose information related to ❑ my personal health information or ❑ the personal health information of _____, for whom I am the substitute decision maker. The information that I am willing to share consists of (check all that apply)**:**

- ❑ Medical information (i.e. family doctor, eye doctor, dentist and orthodontist appointments, as well as Ear, Nose and Throat specialist appointments, hospital visits, etc.)
- ❑ Occupational Therapy Appointments
- ❑ Speech and Language Appointments
- ❑ Psychiatric Consultations and Medication Information
- ❑ Psychological Assessment Reports (only the outcome reports will be shared, not the raw data used to complete the assessment)
- ❑ Individual and Group Therapy Summary Reports (detailed records of therapy sessions will not be released unless there are exceptional circumstances)
- ❑ Family Therapy Summary Reports (detailed records of therapy sessions will not be released unless there are exceptional circumstances)
- ❑ Client Progress Notes (CPNs) and Collaborative Planning Notes
- ❑ Plans of Care and Plan of Care Reviews
- ❑ School Records (Report Cards, Individual Education Plans, etc.)
- ❑ Referral Information (Social History, assessments, etc.)
- ❑ All of the above ❑ None of the above
- ❑ Other**:** _____

(Please print type of information that may be shared)

With**:**

- ❑ Residential Placement Advisory Committee (RPAC)
- ❑ My placing and/or funding agency
- ❑ The local Children's Aid Society
- ❑ My legal guardian and/or parents
- ❑ Medical and health professionals involved in my care
- ❑ My school and teachers
- ❑ Bayfield personnel involved in my care
- ❑ The Commission on Accreditation of Rehabilitation Facilities (CARF)
- ❑ All of the above ❑ None of the above
- ❑ Other**:** _____

(Please print name and address of person requiring the information)

I am aware of the purpose for disclosing this personal health information to the person(s) noted above and understand that this information is needed to plan for my care, treatment, education and/or safety. I understand that I can refuse to sign this consent form and/or withdraw, withhold or provide consent at any time in the future.

I understand that my consent is not necessary if this information is required for matters of safety, as part of a Children's Aid Society or Police investigation, or to ensure Ministry of Children, Community and Social Services licensing compliance. Only that information which is specifically required for these purposes will be shared without consent.

I further understand that if a youth is found to be incapable of making a decision regarding consent, by a health practitioner (after careful consideration of the youth's age, maturity and general level of understanding), then a substitute decision-maker (a person who is authorized under Part X of the CYFSA to consent to, withhold or withdraw consent for the youth) will be asked to decide on the youth's behalf. The substitute decision-maker must provide, withhold, withdraw or refuse consent based on the youth's best interests and take the youth's wishes into consideration.

I have been made aware that if I, the youth, believe that I am capable of providing my own consent when a health practitioner indicates otherwise, I can appeal the decision to the Consent and Capacity Board of Ontario (an independent body that conducts hearings under the Mental Health Act, the Health Care Consent Act, the Personal Health Information Protection Act, the Substitute Decisions Act and the Mandatory Blood Testing Act). I am aware that I have the right to talk to a lawyer to find out more information about this process.

My Name (please print)	Date of Birth	Today's Date

❑ By signing this form, I acknowledge that I understand its contents and consent to the sharing of information as indicated by my choices reflected on the form

My Signature

Note: to revoke consent to release information, please resubmit this form indicating your new level of consent that you wish to provide, including the current date. The most recent form on file will be considered to be the valid form.

Witness Name (please print)	Relationship to the Youth	Today's Date

❑ By signing this form, I acknowledge that its contents have been thoroughly explained to the youth or substitute decision maker and that the above signature was willfully provided by the youth or substitute decision maker

Witness Signature