HealthLink

Muskoka HealthLink

Let's Make Healthy Change Happen

Client Consent Form

Name _____

Date of Birth____/____/_____
(mm/ dd/ yyyy)

I understand that in order to receive the best possible health outcomes, some information relevant to my care may need to be shared in order to:

- Determine eligibility for certain services;
- Provide services;
- Evaluate the services provided and plan programs.

I understand and agree to the collection, use and disclosure of my personal health information with those care providers participating in the Health Link that have put information management practices and systems in place to make sure my information is shared only as necessary to fulfill the purposes described above.

I understand that the Muskoka Community Health Link may ask for permission to disclose some of my information to additional service providers, on my behalf, with my specific agreement.

I understand and agree that the Muskoka Community Health Link will only collect, use and disclose the minimum amount of my personal health information as necessary to fulfill the purposes described above. I also understand that I may:

- Withdraw consent for the sharing of personal health information by notifying my care provider;
- Have access to my information being held by my care provider by making a request to the care provider;
- Find out more about the Health Link and the way it manages my personal health information at www.muskokahealthlink.ca
- Forward any questions I may have about my information or make a complaint if I believe that my personal health information has not been managed properly by contacting:

Health Link: (705) 645-2412 ext.1210

☐ Yes, I have received the Health Link Post Card and have discussed this information with my care team.

Printed Name of Health Link Client or Substitute Decision Maker	**Signature of Health Link Client** or Substitute Decision Maker	**Date** (mm/dd/yyyy)
Printed Name of Witness	**Signature of Witness**	**Date** (mm/dd/yyyy)