Tele-Mental Health Services
provided by

SickKids® vanier CHEO

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 purposed 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