

Counselling Centre

Consent to Collect, Use & Release Personal Health Information

Centennial College collects and protects your personal health information under the authority of the Personal Health Information Protection Act (PHIPA, 2004) for the purpose of providing you services. If you require the collection or disclosure of your personal health information from or to another person, designated agent or agency, please complete the following informed consent form.

I, the undersigned, freely give my authorization to the Centennial College Counselling Centre to (initial all that apply):

_____ release my Personal Health Information

_____ collect my Personal Health Information

consisting of (initial all that apply):

_____ diagnosis and treatment recommendations

_____ assessments, clinical notes and progress reports

_____ other (specify) _____

to/from the following person or organization:

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

for the purpose(s) of (initial all that apply):

_____ communicating with the above-named person or organization in an emergency

_____ creating a health record for my care

_____ ongoing communication with the above-named person or organization

_____ other (specify) _____

Client Name: _____
(Please Print)

Client Signature: _____

Student Number: _____

Date of Birth: _____
(mmm/dd/yyyy)

Today's Date: _____
(mmm/dd/yyyy)

Witness Name: _____

Witness Signature: _____