CONSENT TO RELEASE AND EXCHANGE INFORMATION

|  |  |
| --- | --- |
| First Name: | Last Name:  |
| Student #: | Date of Birth (dd/mm/yyyy): |

Georgian College is compliant with the *Freedom of Information and Protection of Privacy Act* *R.S.O 1990*, and the *Personal Health Information Protection Act*, *S.O 2004*. We endeavour to protect your personal information in accordance with these laws. The staff of Student Success Services at Georgian College treats your information with the utmost respect, privacy and confidentiality. The personal information that we collect from you is collected under the legal authority of the *Ontario Colleges of Applied Arts and Technology Act, S.O 2002*, and in accordance with Sections 38(2) and 41(1) of FIPPA.

I, the above named student, hereby consent to the exchange of information between:

|  |
| --- |
| **Role of staff member: i.e. Adaptive Technologist, Counsellor, Accessibility Advisors, Learning Strategist, Peer Services, Case Manager** |
|  |

And

|  |  |  |  |
| --- | --- | --- | --- |
| **🗸** | **Recipient**  | **Nature of information to be exchanged** | **Initial** |
|  | Campus Safety & Security  |  |  |
|  | Faculty |  |  |
|  | Program Co-ord |  |  |
|  | RARC/Psychologist  |  |  |
|  | Registrar’s Office and Financial Aid |  |  |
|  | Other |  |  |

This consent is effective \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that **only information necessary for the delivery of student success services will be exchanged.** I also understand the purpose(s) for which this information will be shared.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of Student:  |  | Date: |  |
| Signature of Witness: |  | **OVER** |

ADDITIONAL RELEASE OF INFORMATION

**IF** you would like Student Success Services staff to communicate your personal information with anyone else, please fill out the chart below.

Please note that this release of information is **entirely optional and voluntary.**

**This consent may be revoked at any time**. **In no way does revoking this consent affect the delivery of counselling, disability services or learning strategy services to you**. In every instance where information is shared, your Student Success contact will require specific and detailed instructions on what information can be shared.
**I give permission for Student Success Service staff to communicate with these individuals:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Relationship to Student** | **Nature of information to be exchanged** | **Initials** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

This consent is effective \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I understand that **only information necessary for the delivery of student success services will be exchanged.** I also understand the purpose(s) for which this information will be shared.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of Student:  |  | Date: |  |
| Signature of Witness: |  |  |