Consent to Disclose Personal Information
Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

In order to assist you, we are asking for your written permission to obtain information from a third party and/or share all or part of the information from your file at one of our programs within Woodview.

By completing the section below and providing your signature, you are giving us permission to collect and/or share personal information with the individual(s), program, or agency noted below. You may, upon written request, revoke this permission in whole or in part.

I, _____, D.O.B. _____
(Full Name of Child / Youth / Adult) (MM / DD / YYYY)

hereby consent to Woodview Mental Health and Autism Services

☐ obtaining and / or ☐ releasing information about ☐ myself and/or ☐ my family

(check one or both for each)

I, _____, the parent / legal guardian of
(Parent / Guardian Name)

_____, D.O.B. _____, hereby consent to Woodview
(Child / Youth Name) (MM / DD / YYYY)

Mental Health and Autism Services ☐ obtaining and / or ☐ releasing information

about ☐ myself and / or ☐ my child

(check one or both for each)

To _____
(Name of individual or agency)

for the purpose of assessment and treatment planning and service provision.

I understand the purpose for disclosing this personal information to the person noted above. I understand that I can refuse to sign this consent form.

Signature: _____ Date: _____
(Child / Youth / Adult / Legal Guardian)

Signature: _____ Date: _____
(Parent / Legal Guardian)

Witness: _____ Date: _____

Consent is in effect for 12 months OR until _____
(Date withdrawn)

☐ Verbal consent received from client/guardian indicated above.