Consent by Individual

to the Collection, Use and Disclosure of Personal Information
Pursuant to the *Personal Health Information Protection Act, 2004*,
the *Freedom of Information and Protection of Privacy Act*, and
the *Municipal Freedom of Information and Protection of Privacy Act*

To: **Hamilton Niagara Haldimand Brant Local Health Integration Network**

And To: _____**[insert name of Health Service Provider]**

I, _____**[insert name]**, authorize the Health Service Provider noted above and its staff, and the Hamilton Niagara Haldimand Brant Local Health Integration Network (the "LHIN") and its staff, to disclose to each other my personal information including personal health information as appropriate for the purposes identified below and as described by me to the LHIN via _____ **[insert mode of communication i.e. email, phone call, written letter, fax or communicated in person]** on _____ _____ **[insert date]**.

Notice of Purposes and Authority:
The LHIN is collecting the above information in order to inquire further into the concerns that you have raised in relation to services provided or to be provided to you by the Health Service Provider, and in fulfillment of its duties and mandate under the *Local Health System Integration Act, 2006*. The LHIN will only use the information for the purposes described above.

If you have any questions about this collection and use of personal information or the consent form please contact:

Hamilton Niagara Haldimand Brant Local Health Integration Network
Jennifer Gaskell, Manager, Quality and Risk Management
211 Pritchard Road, Unit 1, Hamilton, Ontario L8J 0G1
Phone: 905-526-2312 or 1-866-790-4642 (Fax: 905-574-5148)

I understand that I can refuse to sign this consent form.

_____ _____
Signature Date

_____
Name (please print)