**Punjabi Community Health Services**
**Appendix 'A'**
**Privacy, Confidentiality and Consent Form (BH)**

**Client Name:** ___________________________ **D.O.B** _________________________________

**Program:** ______________________________ **Primary Worker at PCHS:** _______________

## PART A: PRIVACY NOTICE: Collection of Personal Health Information

We collect personal health information about you directly from you or from the person acting on your behalf. The personal health information that we collect may include, for example, your name, date of birth, address, health history, record of your visits to PCHS and the support you received during those visits. Occasionally, we collect personal health information about you from other sources if we have obtained your consent to do so or if the law permits us to do so. We make sure that only those people who need to see your personal records are allowed to look at them. We protect your information through our administrative policies and by adopting appropriate safeguards and security measures.

**Use and disclosure of personal health Information**

We may use or disclose your personal health information to:
• communicate with your various health care providers including your family physician and/or other health care institutions for continuity of care, in order to treat/support and care for you
• plan, administer and manage our internal operations, and conduct risk-management activities;
• conduct quality improvement activities (such as sending client satisfaction surveys);
• teach, conduct research (only under strict rules overseen by a research ethics board) and compile statistics;
• comply with legal and regulatory requirements; and
• fulfill other purposes permitted or required by law.

We can assure you that only staff who need your personal health information for direct care or administrative purposes are authorized to access your record of personal health information. A client's instruction cannot prevent us from recording information that is required by law, professional standards or our practice.

## PART B: Consent to Release and/or Obtain Information

i. I understand that my records are protected and are treated as confidential and cannot be disclosed without my written and informed consent, except in the following cases:
    - A court order or warrant is provided to PCHS;
    - If you pose a significant risk to yourself or others;
    -

- If there is reason to believe that there is abuse or harmful neglect of children under the age of 18

ii. I am aware that I may withdraw my consent at any time through a written letter or verbal consent.

iii. I am aware of all information being disclosed. I have read this form and/or have had it read to me and explained in a language I can understand. I have voluntarily agreed to this release of information and obtaining information without coercion or undue influence.

iv. This consent for the release of information and obtaining information is for the provision of ongoing service, unless otherwise stated above.

I, hereby authorize PCHS

**To Receive Consent for Release of Information and/or Obtain Information:** ☐ None

| ☐ **Family Member** | ☐ **Health Care Provider** | ☐ **Lawyer** |
|---|---|---|
| Name: ___ | Name: ___ | Name: ___ |
| Phone: ___ | Phone: ___ | Phone: ___ |
| Details: ___ | Details: ___ | Details: ___ |
| ☐ Release ☐ Obtain | ☐ Release ☐ Obtain | ☐ Release ☐ Obtain |
| ☐ **Probation Officer** | ☐ **Other** | ☐ **Other** |
| Name: ___ | Name: ___ | Name: ___ |
| Phone: ___ | Phone: ___ | Phone: ___ |
| Details: ___ | Details: ___ | Details: ___ |
| ☐ Release ☐ Obtain | ☐ Release ☐ Obtain | ☐ Release ☐ Obtain |

**For the Purpose of:** ___

This consent was executed on: ___ Expires On: ___
Date Date (if applicable)

## PART C: Electronic and Video Communication Consent

I, hereby authorize PCHS to communicate with me via the following:

☐ Email
☐ SMS Text Messages
☐ WhatsApp Text Messages
☐ OTN – Personal Video Conferencing
☐ Phone

✔ box(es) that apply

PCHS acknowledges that electronic messages are not encrypted and confidentiality can not be guaranteed. Messages can be inadvertently misdirected or intercepted by unintended parties. PCHS will take all reasonable precautions to ensure that any electronic correspondence to clients is not misdirected or otherwise become available to unintended parties. E-mails or text messages sent to, or by a client may be included in the clients file, if clinically relevant. E-mails/text messages are not to be used for urgent matters as they may not be checked daily.

I (the client) have had the opportunity to ask questions about the preceding information. I consent to the boxes that I have checked, acknowledging the guidelines and knowing the potential consequences listed above. I have been explained the implications of this notice in a language I understand.

This consent was executed on: ________________________ Expires On: ___________________
Date Date (if applicable)

**PART D: Participation in Health Link's Care Plan**

Your personal health information will be collected, used and disclosed between the service providers participating in your Health Links Care Plan and this information will be held in confidence and maintained securely in accordance with Ontario's privacy law called the Personal Health Information Protection Act (PHIPA). Your Care Plan will be created through a secure health information system at Central West Local Health Integration Network. This system is managed by Health Shared Services Ontario on behalf of Central West Local Health Integration Network. Health Shared Services Ontario is an agency of the government of Ontario.

This consent was executed on: ________________________ Expires On: ___________________
Date Date (if applicable)

**Client Agreement:**
I have read and understood the above information. I have been explained the implications of this notice in a language I understand.

**Client Signature**:________________________________**Date:** ______________________________

**Witness Signature**:______________________________ **Date:** ____________________________