Interlake Children's Therapy Initiative
Consent for Exchange of Information

Child's Name: _____ Birthdate: _____
Day Month Year

Next of Kin /Legal Guardian _____ Address _____
Street / Box No. City / Town Postal Code

For service coordination, I give permission for the Children's Therapy service partner(s) to exchange personal information and personal health information about my child with the services identified below.

Personal information is protected under *The Freedom of Information and Protection of Privacy Act* (FIPPA). Personal health information is protected under *The Personal Health Information Act* (PHIA). If you have any questions about the collection, use or disclosure of your personal information or your personal health information, please contact Marian Lewis, ICTI Intake Assistant at (204) 785-7730.

Name of Resource or Service	***Name, Address & Telephone #***	***Exchange Information with:***
Family Doctor		☐
Pediatrician		☐
Developmental Pediatrician		☐
Medical Specialist		☐
Child Development Clinic		☐
Foster Parent(s)		☐
Regional Health Authority (RHA)– Therapy Services		☐
RHA – Public Health / Families First		☐
Society for Manitobans with Disabilities (SMD)		☐
Rehabilitation Centre for Children (RCC)		☐
St. Amant Centre		☐
Family Services -Children's disAbility Services (CdS)		☐
Child Care Centre		☐
Nursery School		☐
School and/or School Division		☐
Educational Consultant (Hard of Hearing, Vision)		☐
Hospital / Medical Records		☐
Other:		☐
Other:		☐
Other:		☐

I understand that this consent to the exchange of information is valid as long as my child receives therapy from a CTI partner and that I can have changes made to this consent at any time.

_____ _____ _____

Printed Name of Parent or Legal Guardian Date *Printed Name of Witness*

_____ _____

Signature of Parent or Legal Guardian *Signature of Witness*