CHILDREN'S THERAPY INITIATIVE
Central Region

Consent for Exchange of Information

Child's Name:	Birthdate: (dd/mmm/yyyy)

EXCHANGE OF INFORMATION:

Under Section 22(2)(a) and (g) of the Personal Health Information Act (PHIA) (legislation in the province of Manitoba), referring agencies and other services may exchange information for the purpose of assessment, treatment, further referral and program evaluation.

I understand that information will be exchanged with the individuals I have specified below:

Resource Service ***Name, Agency, Address & Telephone # (all information required)***

Family Doctor _____

Pediatrician _____

Public Health Nurse _____

Child Development Clinic _____

Foster Parent(s) _____

Speech-Language Pathologist _____

Audiologist _____

Physiotherapist _____

Occupational Therapist _____

Service Coordinator (CSS, SMD, CFS, C&A MH) _____

Child Care Centre/Nursery School _____

Student Services Administrator/Resource Teacher _____

Others *(Please provide name, address and telephone number):* _____

_____

_____

Special Instructions: _____

Any other person(s) not authorized under the Act who wishes to receive information or a copy of a report is required to obtain written consent from the individual or their authorized legal representative.

I understand that the information collected may be used as non-identifiable data for planning, program evaluation and research related to the provision of therapy services in collaboration with other service providers in Manitoba.

In the process of obtaining/gathering information about your child, it may be necessary to provide a copy of this form to a provider listed above. By doing this, they will become aware of other service providers named on this list.

This consent for exchange of information is valid for the duration of program participation unless otherwise specified. Parents may request changes at any time.

Signature of Parent or Legal Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

Review Date:		New Form Dated:	