Tele-Mental Health Services,
provided by

SickKids® CPRI CHILD & PARENT RESOURCE INSTITUTE CHEO

LAST NAME	(FIRST)
MRN	VISIT NUMBER
DATE OF BIRTH YYYY-MM-DD	SEX
ADDRESS	

IMPRINT OR ENTER DETAILS BY HAND

Consent to the Disclosure of Personal Health Information

Agency client #: _____ MRN: _____

I, _____ (Enter Name) ☐ Client ☐ Guardian / Substitute decision maker

authorize one of the Tele-Mental Health Service locations to disclose the personal health information of:

_____ (Enter Client Name)

consisting of: **Tele-Mental Health Consultation Report**, _____

To the following: _____ (Enter name of Physician, Mental Health Agency etc.)

_____ (Enter name of Physician, Mental Health Agency etc.)

I, _____ (Enter Name) ☐ Client ☐ Guardian / Substitute decision maker

authorize the **Tele-Mental Health Coordinating Agency** & _____ (Name of Site, Physician, Mental Health Agency etc.)

to disclose the personal health information of _____ (Enter Client Name)

consisting of: _____ (Describe the personal health information to be disclosed)

To one of the Tele-Mental Health Service locations.

Notice of Collection

Information collected through Tele-Mental Health Services will be entered into a data system used to process and schedule appointments, for quality improvement, for approved research studies that do not require information identifying the patient, and for other purposes permitted or required by law. This includes disclosure of personal health information to The Institute for Clinical Evaluative Sciences (ICES) as a prescribed entity for the purposes of section 45 of the Ontario's Personal Health Information Privacy Act. Information collected in this way will be pooled with other similar information and no one participating in this consultation will be individually or specifically identified.

☐ **I agree to be contacted to learn more about research opportunities I / my child may wish to participate in. I am aware that declining to participate in teaching and / or any research related activities will not have any impact on any services I / my child will receive through Tele-Mental Health Services.**

Print name	Signature	Date (YYYY - MM - DD)	Time
Print name	Signature	Date (YYYY - MM - DD)	Time