Coordinated Care Plan Consent Form

Multi-Agency Consent for the Collection, Use and Disclosure of Personal Health Information

Client Name:____ HCN:___________________________

My consent is required for my Care Team to collaborate with me and with each other to develop my Coordinated Care Plan and support me in achieving my goals. This consent allows for the collection, use and disclosure of my personal health information (PHI) with my care team. My PHI will be limited to only what is required for the development and facilitation of my Coordinated Care Plan.

My consent is also required in order to manage my Coordinated Care Plan in a secure electronic system with the North Simcoe Muskoka Local Health Integration Network (LHIN) regardless of whether or not the North Simcoe Muskoka LHIN is involved in my Coordinated Care Plan. Having my care plan stored electronically allows sharing of updates and plans amongst my care providers and may include my previous Coordinated Care Plans (if applicable). The North Simcoe Muskoka LHIN maintains PHI in accordance with the Personal Health Information Protection Act (PHIPA). Collection, use and disclosure of my PHI among my health care providers may include:

- Authorized North Simcoe Muskoka LHIN Staff,
- North Simcoe Muskoka LHIN contracted service providers that provide health care, equipment and supplies as involved in my care;
- Other Health Partners that assist in providing my health care; and,
- Sharing of personal health information with health care partners through regional and provincial systems (e.g. ConnectingOntario Clinical Viewer)

I have the right to know how my information is used, shared and how I can access my information. I may refuse to provide my consent or I can withdraw my consent at any time by contacting any member of my Care team. The Care Team includes individuals/organizations that I have consented to contribute to and be involved in my Coordinated Care Plan.

Restrictions

I do not wish for those listed below to have access to personal health information.

I understand and agree

I am the individual receiving services OR

I am the Substitute Decision Maker (SDM) for the person receiving services

A substitute decision maker is a person authorized under PHIPA to provide consent on behalf of an incapable individual for the collection, use or disclosure of their personal health information.

SDM Name:____

Relationship to Patient:______________________________________

Person Obtaining Consent*: ______________________________________

Title & Designation*: ____

Organization*: ____

Date (YYYY-MM-DD)*:____

*Mandatory

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Care Team		
Name/Organization	**Add to Care Team**	**Lead Organization**