

Consent to Disclosure of Personal Information

I, _____ hereby consent to the disclosure/sharing of information /
(print name in full)
partial information (please specify _____) contained in the record
compiled by the Region of Peel Health Department to _____
(name of agency)
concerning _____ , _____ , _____
(name) (date of birth) (relationship to client)
for the following purpose _____
(purpose)

Return Consent Strike This Section if Not Applicable
This consent further authorizes _____ (Name of Agency) to disclose information contained in the record of _____ (Name) to the Region of Peel Health Department, for the above noted purpose.

This consent remains in effect, unless withdrawn by me in writing, until _____
(Date)

(Signature)

(Witness)

Dated the _____ day of _____ .
(Day) (Month) (Year)

Notice with Respect to the Collection of Personal Information

This information is being collected pursuant to the *Health Protection and Promotion Act*, R.S.O. 1990, c.H.7 and will be retained, used, disclosed and disposed of in accordance with all applicable municipal, federal and provincial laws and regulations governing the collection, retention, use, disclosure and disposal of information including the *Municipal Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c.M.56, and the *Personal Health Information Protection Act*, 2004, S.O. 2004, c.3. This information will be used to provide health care and case management, obtain payment for the provision of health care or related goods or services and for public health administration. Any questions regarding this collection may be directed to the Medical Officer of Health, Peel Public Health, 10 Peel Centre Drive, Suite B, PO Box 2009, STN B Brampton, Ontario, L6T 0E5, 905-791-7800.