HealthLink

South Georgian Bay Community

Participant Consent Form

Name _____ Date of Birth ___/___/____(mm/dd/yyyy)

I understand that the South Georgian Bay Community Health Link (Health Link) is a program to coordinate health care services to make sure that people with multiple care needs receive the best possible care. Health Link services are provided by the Georgian Bay Family Health Team, South Georgian Bay Community Health Centre as well as other providers in the community. Some information relevant to my care may need to be shared in order to:

- Determine eligibility for certain services;
- Provide services;
- Evaluate the services provided; and
- Plan programs.

I understand and agree to the collection, use and disclosure of my personal health information with those care providers participating in the Health Link that have put information management practices and systems in place to make sure my information is shared only as necessary to fulfill the purposes described above.

I understand that the Health Link Navigator may ask for permission to disclose some of my information to additional service providers, on my behalf, with my specific agreement.

I understand and agree that the SGBCHL will only collect, use and disclose the minimum amount of my personal health information as necessary to fulfill the purposes described above.
I also understand that I may:

- Withdraw consent for the sharing of personal health information by notifying my care provider;
- Have access to my information being held by my care provider by making a request to the care provider;
- Find out more about the Health Link and the way it manages my personal health information at www.gbfhta.ca/Health_Link
- Forward any questions I may have about my information or make a complaint if I believe that my personal health information has not been managed properly by contacting:

  South Georgian Bay Community Health Link Privacy Officer
  Georgian Bay Family Health Team
  186 Erie Street, Suite 100
  Collingwood, ON L9Y 4T3
  privacy@gbfht.ca / 705-444.5885 ext 220

_____

Printed Name of Health Link Participant or Substitute Decision Maker

_____

Signature

_____ Date _____

Witness

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