ONE KIDS PLACE
LA PLACE DES ENFANTS
CHILDREN'S TREATMENT CENTRE
CENTRE DE TRAITEMENT POUR ENFANTS

Hands TheFamilyHelpNetwork.ca Mains LeReseaudaideauxfamilles.ca

Private and Confidential

Name of Client:	**Date of Birth:**

CONSENT TO EXCHANGE INFORMATION

I, _____, hereby give consent for the exchange of
Name of Client / Parent / Guardian

information between Hands TheFamilyHelpNetwork.ca (Hands) and One Kids Place (OKP) pertaining to:

_____ _____
Name of Client D.O.B.

for the purpose of: **determining eligibility for the North East Ontario Autism Program**.

In the process of gathering information to determine eligibility for this referral, both agencies must meet the requirements of provincial legislation relating to the privacy of your information. In signing this consent you agree that collecting, storing and disclosing your child's health information is consistent with the Personal Health Information and Privacy Act of Ontario (2004) (PHIPA) and the Agency's privacy statement, except where required by law.

Your child's information, collected in this referral form, will be placed in a common database.

This consent shall remain in effect from this date until the purpose for which the information was disclosed has been achieved, but no longer than one year from the date of my consent. It is understood that I can revoke this agreement at any time either verbally or in writing.

_____
Signature – Client (12 years of age or older)

_____
Signature – Parent / Guardian

_____
Signature – Witness

DATED THE _____ OF _____, 20 _____
Day Month Year

EXPIRY DATE (maximum of one year): _____, _____, 20 _____
Day Month Year