

PROMISE Years

Therapy Services Program

CONSENT FOR EXCHANGE OF INFORMATION

Child's Name:	Birthdate: (Day/Month/Year)
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EXCHANGE OF INFORMATION:

Under Section 22(2) (a) and (g) of the Personal Health Information Act (PHIA) (legislation in the province of Manitoba), referring agencies and other services may exchange information for the purpose of assessment, treatment, further referral and program evaluation.

I understand that information will be exchanged with the individuals I have specified below:

<u>Resource Service</u>	<u>Name, Agency, Address & Telephone # (all information required)</u>
Family Doctor	_____
Pediatrician	_____
Public Health Nurse	_____
Child Development Clinic	_____
Foster Parent(s)	_____
Speech-Language Pathologist	_____
Audiologist	_____
Physiotherapist	_____
Occupational Therapist	_____
Service Coordinator (CSS, SMD, CFS, C&A MH)	_____
Child Care Centre/Nursery School	_____
Student Services Administrator/Resource Teacher	_____
Others Please provide name, address and telephone number):	_____

Special Instructions:	_____

Any other person(s) not authorized under the Act who wish to receive information or a copy of a report are required to obtain written consent from the individual or their authorized legal representative.
I understand that the information collected and exchanged will be used for the purposes of assessment, planning, developing programs and/or strategies that will benefit the child or family. The information may be shared verbally or through written reports. In the process of obtaining/gathering information about your child, it may be necessary to provide a copy of this form to a provider listed above. By doing this, they will become aware of other service providers named on this list.
This consent for exchange of information is valid for the duration of program participation unless otherwise specified. Parents may request changes at any time.

Signature of Parent or Legal Guardian

Date: