POLICY TYPE: INDIVIDUAL SUPPORT SERVICES
(ISS) POLICY TITLE: *CONFIDENTIALITY*

APPENDIX 30: *INFORMED CONSENT AND REFUSAL FORM*

Consent for Collection and Release of Personal Information
EXTERNAL

In support of my services at Lifetime Networks I _____ (participant's name) give consent for the sharing of the following information to the following persons/organizations/professionals. I am aware that the information will be treated confidentially and that it will be shared on a need-to-know basis only.

Information to be Shared

- ☐ Referral and intake information
- ☐ Personal background info including cultural, education
- ☐ Communication Reports
- ☐ Assessments/reports from support professionals
- ☐ Other (specify):
- ☐ Health Care Plans
- ☐ Behavioural Supports
- ☐ Individual Supports
- ☐ Critical Incidents

Those Receiving the Information

- ☐ Family/Caregiver
- ☐ Health Care Professional(s) (specify):
- ☐ Supporting professionals (DDMHT, CRT)
- ☐ Other: If asked for release of your information by someone other than listed above we will ask for your specific permission.

Information requested by:_____

Reason for Request: _____

_____

Date: _____
(Valid for 1 year from Signing)

Signature: _____

Print Name: _____

(see over)

Witness: _____

Print Name _____

Informed
Refusal _____

(If refusal given, complete Risks and Adverse Consequences form)

POLICY TYPE: INDIVIDUAL SUPPORT SERVICES
(ISS) POLICY TITLE: *CONFIDENTIALITY*

Consent for Collection and Release of Personal Information
INTERNAL

This release of information is used for the purpose of consent to share information about a participant with the Lifetime Networks service team to ensure consistent quality support .

In support of my services at Lifetime Networks I _____ (participant's name) give my consent for the collection and sharing of the following information. I am aware that the information will be treated confidentially and that it will be shared with my support staff at Lifetime Networks on a need-to-know basis only.

- ☐ Referral and intake information
- ☐ Health Care Plans
- ☐ Personal background info including cultural, education
- ☐ Behavioural Supports
- ☐ Communication Reports
- ☐ Individual Supports
- ☐ Assessments/reports from support professionals (CRT,DDMHT)
- ☐ Critical Incidents
- ☐ Other (specify):

Date: _____
(Valid for 1 year after signing)

Signature: _____

Print Name: _____

Witness: _____

Print Name _____

Informed Refusal _____

(If refusal given, complete Risks and Adverse Consequences form)

POLICY TYPE: INDIVIDUAL SUPPORT SERVICES
(ISS) POLICY TITLE: *CONFIDENTIALITY*

Risks and Adverse Consequences

I understand that by giving informed refusal the following inherent risks may occur:

_____
_____
_____
_____
_____
_____
_____
_____

I agree to take responsibility for any risks that may occur after this point. If I choose to continue to refuse Lifetime Networks to provide services and exchange relevant information, reports, and contact information, knowing the risks involved, I will not hold Lifetime Networks responsible for damages incurred.

_____
Print Name

_____ _____
Signature Date