MEDICAL TRANSPORTATION CLIENT CONSENT FORM

Three Corners Health Services Society

Section A - Client

Name: _____ Gender: _____
Last Name First Name Initial

Birth Date: _____ Status #: _____ PHN: _____

Primary Address:

_____ Phone: _____
Apt #, Address, City, Province/Territory, Postal Code

☐ *I am a mature minor (i.e. I am under the age of 19 and able to understand my privacy rights and understand the consequences of collection and disclosure of personal information and the statement of consent)*

Statement of Consent:

- I understand that my personal information will be collected, used and/or disclosed for purposes specified below.
- I understand that I can refuse to provide consent.
- I understand that I can withdraw this consent in writing.
- *Three Corners Health Services Society* will collect, use and/or disclose personal health information, for the purpose of:
  - Determining eligibility to access First Nations Health Authority's Medical Transportation program.
  - Inputting information into the electronic medical record.
  - Population of aggregated health information for reporting purposes

This consent gives authorization to Three Corners Health Services Society to exchange information with the following agencies:

- Family Physician
- Specialist(s)
- Hospital(s)
- Physiotherapist(s)
- Dental Therapist/Dentist(s)
- Other (Band, Social Assistance, etc.)

I, _____ agree with the information in the Statement of Consent and hereby give consent.
Client Name

_____ _____
Client Signature Date

Section B – Legal Guardian, Representative, or Temporary Substitute Decision Maker

I,_____, _____ am the legal guardian(s) of the above named Client.
Name of Guardian(s) Name of Guardian(s)

I agree with the information in the Statement of Consent and hereby give consent.

_____ _____ _____ _____
Signature of Guardian Date Signature of Guardian Date