

CONSENT TO THE DISCLOSURE OF INDIVIDUALLY IDENTIFYING HEALTH INFORMATION

(authorized by Section 34 of *HIA*)

I, _____, authorize individually identifying information in the form of:

- Written and/or oral summaries of progress regarding your child
- Assessments completed by the Student Health Program

for _____ to be disclosed by the Student Health Program, in
Name of Child

accordance with Section 34 of the *Health Information Act*, to _____
Name of School

for the following purpose(s):

- To assist your child with problems identified at the time of referral by the parents and school

I understand why I have been asked to disclose individually identifying information, and am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure of this individually identifying information. I understand that this request may be revoked at any time.

Date: _____
(DD/MM/YY)

Expiry Date (if any): _____
(DD/MM/YY)

Client or Legal Representative's Signature

Source of Representative's Legal Authority (refer to Section 104(1) of the Act)

Client or Legal Representative's Name (please print)

Witness Signature

Witness Name (please print)