CONSENT to the COLLECTION, USE and DISCLOSURE OF PERSONAL or PERSONAL HEALTH INFORMATION Page 1 of 2

Please note that a photocopy of this consent form will have the same authority as the original. The original form is not to be removed from the client's file at CBI Health Centre – Regina North.

Maintaining the protection of your personal or personal health information is important to CBI Health (**CBI**) and its affiliated and partnership organizations and is required by law. Our organization is committed to collecting, using, and disclosing personal or personal health information responsibly and **ONLY to the extent necessary for the services we provide.**

Your consent must be freely given, you need to understand the purposes for which CBI will collect, use or disclose your personal or personal health information before you give your consent, and understand that you are able to withhold consent or may withdraw your consent, as discussed below.

Purposes for the collection, use and disclosure of your personal or personal health information by CBI:

- To provide assessment, treatment or other services related to your injury or illness, and/or your claim for compensation or benefits.
- To obtain payment for the assessment, treatment or other services we provide and determine any entitlement to insurance coverage or other benefits.
- To identify treatment outcomes and the extent of services provided and share this information with CBI, payers (for example your insurance company) and referral sources (for example your doctor).
- CBI may also collect, use or disclose your personal or personal health information where required by law to do so.

Withdrawing my consent:

I understand that I may withdraw my consent, in whole or in part, at any time upon providing reasonable written notice to the manager of the clinic I am attending. The manager is responsible for informing me of any potential consequences that may result from the withdrawal of my consent, prior to my making such a decision (for example, it may limit the ability of CBI to provide my assessment, treatment or other services).

If I withdraw my consent, I understand that this is not retroactive, and does not apply to personal or personal health information already collected, used or disclosed by CBI.

Giving my consent:

I acknowledge that I have been made aware of the reasons why my personal and personal health information is needed, and I understand the risks and benefits of consenting or refusing to consent.

My consent is indicated by my signature below and is valid for twelve (12) months from this date or until I withdraw my consent in the manner set out above, whichever comes first.

I, _____ consent to the collection, use and disclosure of my
(print name)
personal or personal health information for the purposes described above.

_____ _____

Signature of client or duly authorized representative: Date:

For more detailed information on CBI Health and its affiliated or partnership companies' policies and procedures with respect to the protection of personal or personal health information please speak to the clinic staff or contact the Chief Privacy Officer, CBI Health, Sun Life Financial Centre, West Tower, 3300 Bloor Street West, Ste. 900, Toronto, Ontario, M8X 2X2, and a written summary will be provided.

CONSENT to the COLLECTION, USE and DISCLOSURE OF PERSONAL or PERSONAL HEALTH INFORMATION
Page 2 of 2

I, _____ **hereby authorize** **CBI Health**
(print name)
or any authorized representative of CBI at 376 McCarthy Blvd. N Regina, Saskatchewan
(Clinic Location)

To:

(Please initial statement(s) A, B, C, as needed, complete name(s) below and sign and date page 2 of the consent form)

_____ **A.** **send copies** (by mail, e-mail or facsimile) or give a verbal report of my assessment, treatment plan, interim progress report(s), discharge plan and follow-up reports as applicable, to the individual(s) / organization(s) named below (Please note that written reports will only be sent to your employer under certain circumstances where this disclosure is necessary to facilitate CBI services or payment, for example if your employer is directly paying for your assessment, treatment or other services and the information in the report is related to, or affects your ability to perform your job).

_____ **B.** **contact** any of the individuals / organizations named below, for the purpose of collecting information regarding my injury, impairment, disability, functional or vocational needs. (Please note that information from your physician may include, but is not limited to, health history, results from tests related to your diagnosis, for example X-rays, MRI or CT scan).

_____ **C.** **contact** my current or previous employer, named below, to discuss the physical demands of my regular employment as related to my injury or illness, the availability of modified or transitional work and to establish a return to work plan as applicable.

Doctor(s)	***Insurance Co / name of adjuster***
Current Employer / name of contact	***Previous Employer / name of contact***
WSIB/ WCB / Nurse Case Manager	***Lawyer(s) / personal representative***
Other (please specify)	

My consent is indicated by my signature below and is valid for twelve (12) months from this date or until I withdraw my consent in the manner set out on page 1 of this form, whichever comes first.

(Signature of client or duly authorized representative)	*(Date: M / D / Yr.)*
(Signature of witness)	*(Date: M / D / Yr.)*
(Address / Location of Witness)	