





## **Creating Your Circle of Care**

Consent to Collect, Use or Disclose Information

By signing this form, I, *print name*\_\_\_\_\_, give my informed consent to participate in services at John Howard/Foundry Campbell River/Foundry Comox Valley, including the collection of relevant personal information so services I have agreed to can be provided. To tailor services, I give permission for my information to be shared between staff of program: \_\_\_\_\_\_, and the following people/agencies.

Select		Name		WHAT CAN BE SHARED* MIN BASICS ALL		
	JH/Foundry Staff					
	Medical					
	Psychiatrist					
	Mental Health					
	Social Worker					
	Education					
	Employment					
	Parent/Guardian					
Res	*Explanations of what can be shared: strictions to consent:	MIN (Minimum) = that you're coming to appointments and participat BASICS = a little about what you're working on (for example "we talk ALL = everything that's going on.		l and anxiety	<i>'</i> ).	
	understand the limits	. I know I can cancel my consent at any		for 90 days for one yea		
				,		
CONSENT EXPIRY DATE		Client Signature Dat	e Signed			
Witnes	ss Name (print)	Witness Signature Dat	e Signed			
*Parent/Legal Guardian Name (print)		*Parent/Legal Guardian Signature Dat	e Signed			

\*Consent must be obtained from parent/legal guardian if client is under 12 years old or an adult incapable of providing informed consent. The John Howard Society of North Island operates under the provisions of the Freedom of Information and Protection of Privacy Act. All information is kept in strict confidence in accordance with the relevant laws and Confidentiality Policy of John Howard.