HealthLink
Huron-Perth
Let's Make Healthy Change Happen

Consent to Share Personal/Health Information

In order for you to receive the best possible health outcomes, it may be necessary at times for the medical team to share some of your personal/health information with a community service agency, which may be providing an important service to meet your needs. The information they receive will be minimal in nature, enough for these agencies to perform their duties outlined in your care, and only given with your consent. Every agency agrees to safeguard this information, and only utilize it for the duration that the service is needed.

By signing the consent form below you are affirming your understanding, and agree to share the necessary personal/health information with the following person(s)/service(s)/agency/agencies listed below as determined in the plan of care or until stated otherwise by you.

_____	_____	_____
Service/Agency	Name	Role
_____	_____	_____
Service/Agency	Name	Role
_____	_____	_____
Service/Agency	Name	Role
_____	_____	_____
Service/Agency	Name	Role

Consent to agree to share the necessary personal/health information:
I, _____, have read and understand the information presented, and hereby consent to have only the necessary personal/health information given to the above listed person(s), service(s) or agency/agencies) for them to perform the duties agreed upon and/or outlined in my care.

_____ _____
Patient Signature Date

_____ for _____ healthcare decision making
Power of Attorney/Family Member Signature Patient Name

_____
Date

Consent has been given to allow the service agency/agencies as listed above to leave messages:
☐ No
☐ Yes Provide name of **contact person** to leave message with:

Name of contact person #1: _____ Phone: _____
Name of contact person #2: _____ Phone: _____