Eastern Health

CONSENT TO OBTAIN/SHARE CLIENT INFORMATION from/with Department of Advanced Education, Skills and Labour

File Number:_____ Program: _____

Client/Applicant		Spouse/Co-Applicant (if applicable)	
Date of Birth	SIN	Date of Birth	SIN
MCP Number		MCP Number	

The Eastern Regional Health Authority may need to obtain client personal information from, or share client personal information with, the Department of Advanced Education and Skills to determine client eligibility for financial support and related services, and to process payments for services for which a client is eligible.

By personal information we mean:

- Client name, age, marital, family and aboriginal status, and education
- Client financial status
- Client identifying numbers such as SIN, MCP or other file numbers assigned to the client
- Information related to the supports and services required.

The information obtained under this consent will be used solely for the purposes listed above and will not be shared with any other person or organization without consent, except as required or permitted by law.

Note: Service may be delayed if this consent is not signed.

CONSENT

In signing this form I agree that the Eastern Regional Health Authority has my consent to obtain personal information about me and my spouse/co-applicant from and/or share personal information about me and my spouse/co-applicant with the Department of Advanced Education and Skills for the purposes of determining eligibility for financial benefits and other services or to process payments for services for which I am eligible.

This authorization is valid for as long as I am receiving financial services from the Eastern Regional Health Authority.

I understand that I can withdraw this consent at any time by notifying the Easternl Regional Health Authority in writing.

Signature of Client/Applicant _____

Signature of spouse/Co-Applicant _____ Date: _____

Substitute Decision Maker (if applicable):

I confirm that I have the authority to act for the client in decisions pertaining to the client's care and services.

_____

Name of Authorized Person (please print)

_____

_____

Signature of Authorized Person