Essex County
Nurse Practitioner-Led Clinic

Clinique dirigée par du personnel
infirmier praticien du comté d'Essex

Informed Consent Agreement

Client Name: _____

NOTE TO CLIENT: ***We want your informed consent. This means we want you to understand the services we hope to provide to you and what we do with the personal Information we obtain about you. We work to provide you with health care services that meet your needs and enable you to seek those services at organizations across the province. In doing so we may need to share your personal health information via fax or an electronic sharing system with other health service providers who are involved in your care.***

- ✓ I understand that I may access services at the Essex County Nurse Practitioner-Led Clinic. The type and extent of services, available options for services, and the risks and benefits of services have been explained to me. I have had the opportunity to ask questions about the services provided.
- ✓ I understand that I have specific rights and responsibilities related to my care. If I choose to participate in ongoing service I understand I will receive additional information about programs, services, privacy and safety.
- ✓ I understand that the agency will collect, use and disclose my personal health information for the purposes of referral, consultation, assessment and provision of services.
- ✓ I understand that an electronic sharing system may be used to share my personal information and/or prescription drug information history with other health service providers, who may need to review the data in order to provide services to me. I understand I may withdraw consent to sharing my assessment and/or prescription drug information in the electronic sharing system at any time.
- ✓ I also understand that this personal health information may be used and electronically shared with other individuals and service providers such as doctors, nurses, care givers, community care providers and other organizations involved in my care in order to provide the most comprehensive services possible.
- ✓ I understand that my use of services and my personal health information will remain secure and confidential. Disclosure of information to others outside those involved in my care will only be made with my consent. I further understand that there are specific exceptions to this confidentiality as explained to me. **Note: The organization has a responsibility to report suspected and/or disclosed reports of abuse, neglect and/or intent to do harm to self or others.**
- ✓ I agree that the information was provided to me in simple, easy to understand language and addressed my cultural beliefs and preferences.
- ✓ I understand that I will receive a copy of this signed consent form.
- ✓ I declare I have read, understood and agree to the contents of this Informed Consent Agreement in its entirety. By signing this form, I confirm I understand the purpose for which my personal health information is collected, used and shared and my privacy rights.

Name: _____ Date of Birth: _____ Relationship: _____
(Client, Guardian or Substitute Decision-Maker if applicable) MM/DD/YYYY (If signing for someone else)

Signature: _____ Todays Date: _____
(Client, Guardian or Substitute Decision-Maker if applicable) MM/DD/YYYY

File:
- ☐ Recorded in EMR
- ☐ Copy to client
- ☐ Withdrawal of Consent for: Specify:

This authorization will remain in effect until revoked by you.
If you wish to limit the duration of this authorization, please specify the end date below: