Saskatchewan Health Authority

Acquired Brain Injury (ABI) Program
Health Information Consent to Release

Patient Information		
Name	Preferred	Health Services Number
Date of Birth (mmm-dd-yyyy)	Current Telephone Number Home ( ) Cell ( )	
Address		
City	Province/ State	Postal or Zip Code

Guardian or Substitute Decision Maker Information, if applicable *Assignment required*	*Confirmation of SDM/Proxy*	
First and Last Name	Relationship to Patient	Telephone Number

STATEMENT OF PATIENT CONSENT

I have been provided *CS-PIER-0019 Acquired Brain Injury Program* to review and been given the opportunity to ask questions and all my questions have been answered.

I am authorizing the **Acquired Brain Injury team** to be a part of my on-going care and to obtain and share information and data about me with such people and organizations in the manner set out in this consent form (page 2).

The Saskatchewan Health Authority collects, uses, and discloses personal health information only in accordance with *The Health Information Protection Act* and personal information under *The Local Authority Freedom of Information and Protection of Privacy Act*. In accordance with section 6 of HIPA, express consent can be writing or verbal. If my consent is provided verbally the date, time and method of collection will be documented here.

I understand I can choose not to participate in the program or revoke my consent to participate at any time. Please note that while your withdrawal will take effective immediately, it will not be retroactive (any information shared cannot be retrieved).

Unless revoked, this authorization endures for 2 years. If the length of your **ABI program** involvement is less than 2 years, it terminates with your end. If your involvement exceeds 2 years the authorization will be renewed.

Signature of Patient/ Confirmed Proxy: _____ Date: _____

Signature of Witness: _____ Date: _____

I am choosing to **revoke my consent to release information**, as of today _____, 20____, to the involvement of the ABI program, as previously agreed to above. I understand I may be able to obtain/receive individual service(s) from the ABI Team noted above now or in the future by contacting the program staff.

_____ _____
(Patient or Proxy Signature) (Witness s Signature)

_____ _____
(Date) (Date)

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Name:_____ **HSN:** _____

External Organizations and Service Providers I consent to share my health information with (Initial under ID):

ID	Organization	Name and Telephone	Initials for Additions/ Deletions	Date Changes Made
	Family Doctor			
	Family Member			
	Community Day Program			
	Special Care Home			
	Ministry of Social Services			
	WCB			
	SGI			
	Place of Education			
	Place of Employment			
	Early Childhood Intervention			
	Child and Youth Services			
	Residential Program			
	SaskAbilities Council			
	Independent Living Workers and Mentors			
	Ministry of Justice			
	Ministry of Health			
	Other			
	Other			
	Other			
	Other			

The following internal SHA departments will use your information if involved with them. If you do not wish your information shared with the following departments, you should decline the referral to the individual department.

ABI Regional Coordinator	Child and Youth Services
Primary Health Care Network	Psychology
Neurosurgery	Physiatry
Neuropsychology	Psychiatry
Neurology	Health Records
Social Work	Mental Health Services
Addictions Services	Rehabilitation Medicine In-Patient/Out-Patient