CONSENT TO SHARE INFORMATION
between Brant Service Coordination Partners

In respect of _____, _____
(Child/Youth's Name) (Date of birth)

_____
(Address)

Coordinated Service Planning is a commitment between Brant organizations who serve children and youth with multiple needs, to support their families with a clear point of contact for all the services they are receiving, and provide a single service plan that identifies what is important to the family.

To make a referral to a service, or to work together on behalf of your child and family, we need your permission to communicate between the various organizations involved with your family about your child's needs, progress, and planning.

Your consent allows for agency staff to communicate with each other.
Your consent allows for agencies to share written reports (such as an intake, service plans, and assessments).

In Brant, Contact Brant is the lead Service Coordination Agency and is mandated to keep information of Coordinated Service Planning clients on file. Contact Brant protects the privacy of your information - All information is treated as confidential and is not released or discussed with any other persons or organizations without consent, unless required by law.

I give my consent to the organizations that I have checked and initialled on the second page of this form to **talk with each other about the services my child is receiving, being referred to, or is waiting for, as well as my child's needs, progress and planning**.

I give my consent to share the reports listed that I have checked and initialled on the second page of this form with these same organizations.

I understand that organizations will not willingly disclose information without permission, unless required by law.

I understand that the information collected is stored at Contact Brant as required by their provincial funders, the Ministry of Children and Youth Services.

I also understand that information collected is used in a non-identifying summary form for community planning, quality assurance, and Ministry reporting.

This consent will remain in effect for one year from date of signing. I understand that I may cancel this consent in writing at any time.

Print **Name of Staff** who reviewed & received Consent with Consenter(s):	**Organization**:
Date Consent Reviewed:	**Signature of Staff**

Consent to Share with:	✓ **Purpose:** Referral to Service(s)	✓ **Purpose:** On-going communication	**Initial to Approve consent as checked**	**Initial if consent is Declined**
Affiliated Services for Children and Youth				
BHNCDSB - specify school:				
Brant County Health Unit				
Brant Family and Children's Services				
Community Care Access Centre HNHB				
Conseil scolaire de district catholique Centre-Sud - specify school:				
Contact Brant				
CPRI (Child & Parent Resource Institute)				
De Dwa Da Dehs Nye>s (Aboriginal Health Centre)				
Developmental Services Ontario HNR				
Family Counselling Centre of Brant				
GEDSB - specify school:				
Lansdowne Children's Centre				
McMaster Children's Hospital				
Physician (Family/Specialist): Dr.				
Six Nations of the Grand River specify agency:				
Six Nations/New Credit Schools - specify school:				
St. Leonard's Community Services				
Woodview Mental Health and Autism Services				

Report	**Source of Report** and **Date**	**Initial Consent to Share Report**
☐ Intake Report		
☐ Coordinated Service Plan		
☐		

List any specific instructions by Consenter:

Print Name of Consenter:	Relationship:	Print Name of Consenter:	Relationship:
☐ Verbal Consent OR ☐ Written Consent – Signature:		☐ Verbal Consent OR ☐ Written Consent – Signature:	
Date:		Date:	