Cochrane Case Collaboration for Children and or Youth Consent Form

For the purposes of planning, providing, and/or coordinating services:

I, ___________________________________, consent that the following agencies/organizations may collect, use, and disclose only pertinent personal/health information among themselves about my child/youth ___________________________ (name). This applies to both verbal and written/recorded information.

The Core Collaboration Team includes professionals as indicted below.

- Calgary Foothills PCN Family Physician and Nurse or Behavioral Health Consultant
- AHS Cochrane addiction and mental health therapist
- FCSS Resource Team Youth Worker (Social Worker)
- Rocky View or Catholic School District (Family School Liaison/ counsellor and or Principal)
- Your family Physician (guest)____________________
- Family member (guest)________________________
- Family Supports for Children with Disabilities (Case Lead)
- Community Pediatrician
- Boys and girls club youth Program Coordinator
- RCMP School Resource Officer / Youth Liaison Officer
- Cochrane Children Services (Intake worker)
- Pediatrician (guest) ________________________
- Participative agency (guest) ________________________

Please do not share the following information with the following people/programs.

Authorization

I understand the professionals/organizations involved are required to protect my personal/health information; and use and disclose it only with my consent or as permitted/required by law including the Child First Act, Health Information Act, Personal Information Protection Act, Freedom of Information and Protection of Privacy Act. Personal/Health information that is collected, used, and /or disclosed among the professionals involved will be maintained and kept confidential by each professional in accordance with privacy laws, and their organization's standards and regulations.

I understand there is a legal obligation on the professionals/organization involved to report certain information (i.e., abuse, information about imminent harm to self and others, etc.) and that such information cannot be held in confidence.

I authorize professionals/organizations involved to disclose my child's personal/health information described above to the individual or organizations(s) identified above. I understand why I have been asked to disclose my child's personal/health information and I am aware of the risks and benefits of consenting or refusing to consent. I understand I may revoke this consent in writing at any time and that revoking my consent will not affect any action already taken by professionals/organizations or recipients of the personal information, before they received written notice of my revocation, or affect future service.

Child/Youth, or Parent/Guardian/Substitute Decision Maker	Witness	Date
This consent is effective until (limit two years)	Name of Organization	Organization representative

Completed consent collected for the purpose of the case collaboration need to be stored in own agency's respective records as directed by the agencies policy and procedures manual.
(June 2021)