Toronto Central **LHIN**

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Toronto Central Local Health Integration Network

Consent by Individual to the Collection, Use and Disclosure of Personal Information

Pursuant to the *Personal Health Information Protection Act, 2004*, the *Freedom of Information and Protection of Privacy Act*, and the *Municipal Freedom of Information and Protection of Privacy Act*

To: Toronto Central Local Health Integration Network

And To: _____ *[Insert Name of Health Service Provider]*

I, _____*[name]* authorize _____ *[Health Service Provider]* and its staff, and the Toronto Central Local Health Integration Network *[the "LHIN"]* and its staff, to disclose to each other my personal information including personal health information as appropriate for the purposes identified below and as described_____ *[insert mode of communication i.e. in an email, telephone call, written letter or other]* by me to the LHIN on _____ *[insert date].*

Notice of Purposes and Authority:

The LHIN is collecting the above information in order to inquire further into the concerns that you have raised in relation to services provided or to be provided to you by the Health Service Provider, and in fulfillment of its duties and mandate under the *Local Health System Integration Act, 2006*. The LHIN will only use the information for the purposes described above.

Ontario
Local Health Integration Network

If you have any questions about this collection and use of personal information or the consent form please contact:

Toronto Central Local Health Integration Network
425 Bloor Street East, Suite 201
Toronto, ON M4W 3R4
Tel: 416-921-7453
torontocentral@lhins.on.ca

I understand that I can refuse to sign this consent form.

_____ _____

Signature **Date**

_____

Name (please print)