



Consent to the Collection, Use & Disclosure of Personal Health Information

- Quest CHC uses a team approach. Your medical record is confidential. We do not share information outside of the ‘circle of care’ without your consent except when required by law, for safety and/or to protect life.
- I agree that I have read the **Statement of Personal Health Information Practices** and have had the information explained to me.
- I understand the information provided, and I have had an opportunity to have my questions answered by a Quest CHC staff member.
- I understand I can give consent, withdraw consent or refuse to give consent. However, withholding necessary personal health information from Quest CHC staff may affect or limit my care and treatment.

I, _____

_____	_____
Client’s Full Name (Print)	Client’s Date of Birth

agree with the collection, use and disclosure of my personal health information as described above.

**Signature of Client
(or Substitute Decision Maker)**

Date

Signature of Quest CHC Staff Member

Date

Name of Quest CHC Staff Member (Print)

