

## APPENDIX 6.1: CONSENT BY INDIVIDUAL

### **Erie St. Clair Local Health Integration Network**

#### **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: Erie St. Clair Local Health Integration Network**

**And To:** \_\_\_\_\_

I, \_\_\_\_\_, authorize \_\_\_\_\_ (“Health Service Provider”) and its staff, and the Erie St. Clair Local Health Integration Network (the “LHIN”) and its staff, to disclose to each other and to use my personal information including personal health information as appropriate for the purposes identified below and as described

\_\_\_\_\_ by me to the LHIN on  
\_\_\_\_\_.

#### **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.

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

Erie St. Clair Local Health Integration Network  
Julie Franchuk  
Communications Specialist  
180 Riverview Drive, Chatham ON N7M5Z8  
1-866-231-5446 ext. 3215

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name (please print)