



Young Adult
Mental Health

Stella's Place Consent Form

Consent to Disclose Personal Health Information

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I, _____
(Name of Young Adult or Substitute Decision Maker "SDM")

Of _____
(Address)

Authorize the disclosure and collection of personal health information between:

_____ and
(Name of person/agency disclosing information)

_____ Stella's Place Assessment and Treatment Centre
(Name of person/agency requesting information)

With regards to:

_____ (Name of Young Adult) _____ (Date of Birth)

_____ (Address)

All information obtained will be kept confidential between the parties specified above. I understand that I may withdraw this authorization at any time in writing.

Name of Young Adult/SDM – please print

Name of Witness – please print

Signature of Young Adult/SDM

Signature of witness
