**Community Common Consent Form – Child / Youth / Adult**

Sea to Sky Corridor Communities

At \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ you/your child can expect confidential, equitable and respectful care. Our goal is to work with clients to create a circle of care that provides the most effective treatment or intervention options to foster the greatest likelihood for improvement to your mental wellness. Participation is voluntary.

Your/your child’s circle of care may include wrap-around supports such as service providers, Doctors, family, colleagues, teachers, therapists, or others. Only with your permission can we share information with others.

The important roles that support people can play in recovery from mental health and substance use challenges are well documented. These roles, and their value, have been recognized by professional groups and government bodies, many of which have called for increased family involvement in all areas of activity.

Are there support people who you would like us to share information with about your care? **Yes**  **No**

For the purposes of planning, providing, and/or coordinating support services for **me or** **my child (circle one),** I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ consent that the following organizations or agencies may collect, use and disclose ONLY relevant personal information among themselves about me/my child. This applies to any verbal, written or otherwise recorded information.

|  |  |  |  |
| --- | --- | --- | --- |
| Name/Organization | Contact#/Email | Relationship | Client’s Initials |
| Name/Organization | Contact#/Email | Relationship |  |
| Name/Organization | Contact#/Email | Relationship |  |
| Name/Organization | Contact#/Email | Relationship |  |

Some of the benefits to sharing information within your circle of care, include:

* Eliminates duplicate Intakes
* Reduces the number of times that you need to repeat your story
* Reduced the number of basic questions that you are asked about your situation
* Multiple services can be coordinated and streamlined

**CONSENT:**

**I understand that the professionals and organizations involved are required to protect my personal information and use and disclose it only with my consent or as permitted/required by law. Personal 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 organizations’ standards and regulations.**

**I understand that there is a legal obligation on the professionals/organizations involved to report certain information (ie: abuse, information about imminent harm to self and others, etc.), or soebena by courts, and that such information cannot be held in confidence.**

**I understand that I may revoke this consent at any time and that revoking my consent will not affect any action already taken by professionals/organizations or recipients of my personal information, before they received written notice of revocation, or affect future services.**

Name of Participant/Youth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (Participant/Parent/Guardian): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_