



Nigonigawbow Band Representative

Wabaseemoong Independent Nation • P0X 1P0 • Telephone: (807) 927-2000

Consent Form

Why Personal Information needs to be collected:

The Band Representative Program provides many support services and access to resources for Wabaseemoong families. In order to provide these services, we coordinate the activities of a number of internal and external resources and consult with each other. The Band Representative staff may need to share information regarding you/your child’s specific needs and/or support a personal plan, i.e. intervention, treatment plan, training needs and how they will be met towards achieving stated goals.

Consent for the Use and Disclosure of Personal Information:

By allowing this Consent to share personal information, we can help other service providers better understand, your requested service needs in a most expedient manner.

Purpose of Consent

I consent to the sharing of my/ my child’s personal information between the organizations/agencies listed below. The purpose of sharing information about me /my child is to allow the service providers from each agency to discuss my /my child’s situation and develop a complete service plan that will address my /my child’s social service needs.

Initial: _____

Confidentiality

I understand that the information shared will be on a need to know basis only. It is also my understanding that each of the participating organizations/agencies listed below will maintain confidentiality of the information in accordance with standard organization/agency and government policies, legislation such as such as The Freedom of Information and Protection of Privacy Act (FIPPA), The Personal Health Information Act (PHIA) and Regulations, federal Privacy Act, the Access to Information Act, and any other applicable legislation. By signing this document I am consenting to having the resources contacted by the Band Representative program with the contact information provided on the intake form.

Employment Income Assistance/Ontario Works (city, rural or on-reserve)

Mercury Disability

Wabaseemoong Donations request via finance

Jordans Principle Navigators

Employment Income Assistance – Disabilities

Children’s Disability Services

Child and Family Service Agency _____

Addictions Foundation Manitoba

Native Addictions Foundation

Housing Services (other housing services)

Treatment Centre

Community Mental Health

Community Living DisABILITIES _____

School (name) _____

Other(s): _____



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Maintaining Confidentiality of Information

I understand that any other use or disclosure of this personal information will NOT be permitted without my consent, unless so authorized by the law, particularly by FIPPA, the PHIA, the Youth Criminal Justice Act (YCJA), and The Child and Family Services Act (CFSA).

Contact Information

If there are any **questions or concerns** about the collection, use, sharing or disclosure of my personal and personal health information, I can contact the Kris O’Cheek.

Expiry of Consent

I understand that I may **revoke this Consent** at any time in writing. I further understand that this consent will expire one (1) year from the date signed. I know that I can withdraw my consent or make changes to it at any time by contacting Kris O’Cheek

Copy of Form

A copy of this notice and consent form will be provided to me.

Authorizing Signature(s)

I have read this **notice, it has been explained** to me and I understand it enough to provide informed consent.

Initial: _____

I consent to the Nigonigawbow Band Representative accessing the information as noted on this form and sharing it where relevant and necessary. This will be where doing so is directly related to participation in Band Representative Services and Care Plan.

Initial: _____

I am aware that this consent form will be kept on Nigonigawbow Band Representative file. It will be given to the agencies and departments from which the Nigonigawbow Band Representative is seeking or sharing information, where necessary to support my needs. I/the will be informed when this occurs.

Initial: _____

Printed Name of Client

Signature of Client/ or Legal Guardian

Date

Printed Name of Witness

Signature of Witness

Date