Grandview Children's Centre
600 Townline Road South, Oshawa, Ontario L1H 7K6
Tel. 905-728-1673 Fax. 905-728-2961

COMMUNICATION AUTHORIZATION FORM

CLIENT NAME:	Chart #:
CLIENT ADDRESS:	BIRTH DATE:
	HEALTH CARD #:
MOTHER'S NAME:	
ADDRESS: ☐ Same as above OR:	
EMAIL ADDRESS:	
FATHER'S NAME:	
ADDRESS: ☐ Same as above OR:	
EMAIL ADDRESS:	
CUSTODY: Parents: ☐ Joint: ☐ Exclusive: ☐ Special Arrangement:(Specify)	

In order to keep parents informed of their child's progress, copies of all Grandview/Preschool Outreach Program/ Durham Preschool Speech and Language Program reports are routinely provided to parents at the client's address.

To ensure the best client care, Grandview may share your personal health information with those people who need it for their work with you and your family or with those who have a right to it by law. This could include:

- therapists, medical staff and associates, both within and outside of Grandview
- student trainees, volunteers, and support staff
- authorized individuals who are reviewing records for quality improvement purposes
- other individuals, if you agree, or when the law requires or permits it.

Limited information (such as your name, address and email address) may be used by Grandview or its Foundation to request your participation in a survey, to provide you with news about our programs, services and special events or for fundraising purposes to improve our health care services.

In addition, it may be beneficial, at times, for us to communicate with other agencies who are also providing a service to your child. Please read the following statement and provide a specific list below of individuals or agencies that you feel may benefit from communication with Grandview staff.

I hereby authorize Grandview Children's Centre, through the staff of the Centre, to communicate with and to provide verbal and/or written information regarding the above named client to the following professionals and/or agencies. I understand that 'written' communication may involve transferring information by fax machine and, in some cases, by e-mail using Grandview's secure ACCESS email server. I also understand that I may withdraw consent by contacting Grandview's Privacy Officer at 905-728-1673, ext. 2259.

1. Physician(s) _____
2. Hospital(s) _____
3. School Board/ School/Preschool _____
5. Community Agencies _____
6. Other _____

I understand that it is my responsibility to notify the Centre in writing of any change in the above. I further understand and agree that this authorization shall remain in force until expressly revoked by myself or other person authorized to do so, or until the client's discharge from the Centre.

_____ _____
Signature of Witness Client/Parent/Legal Guardian

_____ _____
Date Relationship to Client