FRESH START MATERNITY SUPPORTS

CONSENT TO EXCHANGE INFORMATION

(NO check marks, Client MUST INTITIAL each contact, professional and service relevant to her case)

I, _____, authorize the staff members of Fresh Start Maternity Supports to exchange information (verbal or written summaries only. This does NOT include obtaining copies of case notes or access to entire client file) with staff of the following:

___ Family Member(s) _____
_____
*___ Emergency Contact _____
___Partner_____

Professionals

___ Lawyer _____
*___ Tutor
___ Other _____
*____Current Family Physician name & contact:_____
*___ Psychiatrist/Psychologist _____

Services

*____ Family & Children's Services (CAS) _____
*____ Family & Children,s Services(CAS) St Thomas
*____ Addiction Services of Thames Valley
*____ Adult Learning Centre—TVDSB
*____ Canadian Mental Health Association
*____ Regional Mental Health
*_____CCHC (local health centre)
*_____Elgin /St. Thomas Health Unit (public health nurse visits weekly)
_____ Family Service Thames Valley
_____London Crisis Pregnancy Centre _____
*____ Ontario Works/ODSP _____
*____ Probation & Parole _____
_____Reconnect (school program)
_____ Regional Support Associates
*_____ Volunteer placement_____
*_____ STEGH (local hospital)
_____ Violence Against Women
_____ Pastor _____
_____ Julie Hayes (program facilitator & coach)
_____ Other_____,_____, _____

in order to assist me in my application process and program of care. This form pertains to:

- ❑ Me (DOB _____)
- ❑ My child/ren Name: _____ DOB _____
  Name: _____ DOB _____
- ❑ Other
  Name: _____ Relationship: _____ DOB _____)

*Consent is valid from date of application dated: _____to 6 months post discharge unless revoked in writing. Revoking consents may affect placement status. *If applicant is declined residency, consent is null and void as of decline date.

_____ _____
Signature of Applicant *Date*

_____ _____
Signature of Witness *Date*

  FAX THIS FORM WHEN COMPLETE TO 1-866-245-1774