Saskatchewan Health Authority

Autism Spectrum Disorder Department
1000B Albert Street
Moose Jaw, SK S6J 2Y2
P: 306-691-2308 | F: 306-691-2330

Moose Jaw Autism Spectrum Disorder Program

CONSENT FOR EXCHANGE OF INFORMATION

I, _____ (client/parent/guardian), give permission to the **Moose Jaw Autism Spectrum Disorder (ASD) Program** to **share and receive information**—either verbally or in written form—regarding assessments, interviews, and procedures related to:

_____ (child's name).
This information may be exchanged with the following individuals or service providers:

Agencies / Professionals Authorized for Exchange			
Agency / Provider	**Name of Contact (if known)**	**Date of Consent**	**Parent Initials**
Audiologist			
Day Care (Specify):			
Early Childhood Intervention Program			
Early Learning & Child Care Consultant			
Family Physician / Nurse Practitioner			
Pediatrician			
Mental Health & Addictions			
Occupational Therapist			
Physical Therapist			
Psychologist			
Public Health Nurse			
School Professionals			
- School Division (specify):			
- Teacher			
- Teacher Assistant			
- Student Support Teacher			
Speech-Language Pathologist			

Agencies / Professionals Authorized for Exchange			
Agency / Provider	**Name of Contact (if known)**	**Date of Consent**	**Parent Initials**
Wascana Rehabilitation Centre, Regina			
Family Resource Centre Professional			
Community / Other Agencies			
- KidsFirst			
- Social Worker			
- Family Resource Centre Staff			
- Recreation Program Staff			
- Spiritual Program Staff			
- RCMP / City Police			
Ministry of Justice – Community Corrections			
Ministry of Social Services			
Other (Please Specify):			

☐ **Interpretation Services used to complete form.**

Restrictions:
Please note any specific restrictions or limits to the sharing of information (optional):

Consent for Exchange of Information

I, _____ (client/parent/guardian), hereby provide consent to the **Moose Jaw Autism Spectrum Disorder (ASD) Program** to exchange information related to my child's assessments, treatment, and care. This consent may be **limited** to a specified duration or specific purposes, as described below, or for the entire duration of my child's participation in the program.

Option 1: Full Consent (Duration of Program)

I give my consent for the exchange of information **for the entire duration** of my child's participation in the Moose Jaw ASD Program. This includes the sharing of information with the agencies, professionals, and service providers listed below for purposes related to my child's assessment, treatment, and care.

Responsibility to Update Information: I understand that it is my responsibility to **notify the Moose Jaw ASD Program if I wish to update or change the agencies, professionals, or service providers listed for the exchange of information**. This includes notifying the program of any new contacts or providers who should be added or any existing contacts who should be removed from the consent.

I understand that my child's information will only be shared for the purposes of assessment, treatment, and coordination of care, and that I will be notified if any changes to this consent are required.

Signature of Client / Parent / Guardian: _____

Printed Name: _____

Relationship to Child: _____

Date: _____

Witness (if applicable): _____

Option 2: Limited Consent

I give my consent for the exchange of information **only for the purposes and duration** specified below:

- **Time Period for Consent**:
  From: _____ to _____ (DD/MM/YYYY)

Please check the relevant option:
☐ **Limited to a specific service** (e.g., Occupational Therapy only)
☐ **Limited to a certain time frame** (e.g., 6 months, 1 year, etc.)
☐ **Limited to specific professionals/teams** (e.g., only the School Division)

I understand that my child's information will only be shared for the purposes of assessment, treatment, and coordination of care, and that I will be notified if any changes to this consent are required.

Signature of Client / Parent / Guardian: _____

Printed Name: _____

Relationship to Child: _____

Date: _____

Witness (if applicable): _____

Terms of Consent

- **Duration of Consent**: This consent applies either for the full duration of my child's participation in the Moose Jaw ASD Program or the limited period specified above.
- **Right to Withdraw**: I understand that I may **withdraw this consent at any time** by providing written notice to the Moose Jaw ASD Program. Withdrawal of consent will not affect any actions taken prior to the withdrawal.
- **Ongoing Communication**: If the consent is for the full duration of the program, the information will be shared regularly as necessary for coordination of care. If the consent is limited, only the specified information and for the limited purposes mentioned will be shared.