Santé
et Services sociaux
Québec

DT9196

CONSENT TO SHARE PERSONAL INFORMATION UNDER THE INTEGRATED SERVICE NETWORK FOR THE ELDERLY (RSIPA)

I, the undersigned, _____ , understand

- the purpose of the Integrated Service Network for the Elderly (RSIPA) in the area served by the Health and Social Services Center (CSSS) of _____ , and who its partners are (mentioned on the following page);
- that there may be situations where it is necessary to share my personal information (mentioned on the following page) to provide the care, interventions, and services required by my state of health and psychosocial needs;
- that this information may have been collected before my arrival in the RSIPA, e.g., medical results added to my record prior to that date, if they are relevant to the care and services I may receive;
- that my personal information is stored safely and can be consulted by health practitioners who are caring for me under the RSIPA. These practitioners may also add information to my RSIPA file;
- that only authorized personnel, namely my treating physician and the practitioners at RSIPA member or partner establishments and organizations in my region, have access to my personal information;
- that I may, at any time, ask to see my RSIPA file to check my personal information by contacting the _____ CSSS;
- that I may, at any time, ask that any information I feel is incorrect, incomplete, or ambiguous be corrected;
- that my consent to share my personal information is valid for two (2) years as of the signing date;
- that I may, at any time, withdraw my consent to share my personal information, either verbally or in writing. Withdrawing my consent will in no way prevent me from receiving care, interventions, or services from the various RSIPA partners.

I hereby certify that

- I have read (alone or with assistance) and understood this consent form;
- I have received and read the leaflet explaining the role of RSIPA;
- I have had the opportunity to ask, and receive satisfactory answers to, all my questions;
- I had sufficient time to make my decision;
- I freely accept that my personal information be shared with RSIPA partners.

I hereby confirm that all the blanks in this form were completed before I signed.

☐ **CSSS copy** ☐ **Copy of the patient or his/her representative**

File No.	

By signing this form, I hereby authorize the sharing of my personal information for the purpose of organizing the care, interventions, and services required by my state of health and psychosocial needs.
This authorization is granted to the Integrated Service Network for the Elderly (RSIPA) in the area served by the

_____ CSSS, and will be reviewed on _____ .
(year/month/day)

_____	_____	_____	_____
Signature	Name (please print)	Date	Time

_____	_____	_____	_____
Signatory's address		Postal code	Area code Phone No.

OR

By signing this consent form, I hereby authorize the sharing of information

concerning _____ , who I represent, for the purpose of organizing the care, interventions, and services required by his/her state of health and psychosocial needs.
This authorization is granted to the Integrated Service Network for the Elderly (RSIPA) in the area served by the

_____ CSSS, and will be reviewed on _____ .
(year/month/day)

_____	_____	_____	_____
Signature	Name (please print)	Date	Time

_____	_____	_____	_____
Signatory's address		Postal code	Area code Phone No

I have explained this consent form to the person I represent and answered all their questions.

_____	_____
Signature of the person who obtained consent	Name of the person who obtained consent

Personal information required by RSIPA:

- Sociodemographic data (e.g., name, address)
- Medical history (e.g., diagnoses, illnesses)
- Results of diagnostic tests (e.g., x-rays)
- Pharmacological profile (e.g., all medications)
- Service requests (e.g., homecare services)
- Evaluation and consultation reports (e.g., physiotherapy, orthopedics)
- Service plan (document listing needs, care organization, services provided, etc.)
- Progress notes (to track patient's health)

RSIPA Partners:

The partners of my local RSIPA include all the establishments and organizations in my region that have signed an agreement with the _____ CSSS or that will sign such an agreement during the validity period of my consent, namely:

- Hospital centers
- Hospitals
- Residential and long term care centers (CHSLD)
- Homecare centers
- Rehabilitation centers (CR)
- Medical clinics
- Family medicine groups
- Pharmacies **(name all potential partners)**

_____

- Community organizations
- Other: _____

Due to their geographical proximity, the following establishments or organizations have also signed agreements with the _____ CSSS
(Name all "special" partners in other regions.).

_____

_____