Santé et Services sociaux Québec

DT9197

Sharing of personal information under the Integrated Service Network for the Elderly (RSIPA)

CONSENT WITHDRAWAL

I, the undersigned, _____ , hereby withdraw the consent I granted at an earlier date to the partners of the Integrated Service Network for the Elderly (RSIPA) in the area served by the _____ Health and Social Services Center (CSSS) with regard to 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. I understand that, starting _____ (year/month/day) , none of my personal information (mentioned on the following page) will be shared outside the establishment where I receive care, interventions, and services.

I understand that my personal information that has already been shared, with my consent, with the network partners who have provided me with health or social services as at the date of my consent withdrawal will continue to be available to these, and only these partners.

I understand that only by signing a new consent form will this withdrawal be annulled.

I hereby confirm that I have had the opportunity to ask, and receive satisfactory answers to, any questions I may have had.

Signature	Name (please print)	Date	Time

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

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

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

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.)**.

_____

_____

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