



PROVINCIAL RESPIRATORY OUTREACH PROGRAM

MANDATORY CLIENT INFORMATION AND RELEASE FORM (PLEASE PRINT)

PERSONAL INFORMATION

Name of Applicant: _____
(First) (Last)

Date of Birth: _____ M/D/Y Gender: M: [] F: [] Date of Application: _____ M/D/Y

Name of Current Care Residence (if applicable): _____

Street Address: _____

City: _____ Postal Code: _____

Phone: _____ (ext) Fax: _____ Email: _____

Home Address if different from above:

Street Address: _____

City: _____ Postal Code: _____

Phone: _____ (ext) Fax: _____ Email: _____

CONTACT PERSONS

(i.e., A person who will assume responsibility for completion of forms, arranging appointments, etc. if client is unable to do this.)

Primary Contact:

Name: _____ Relationship to client: _____

Street Address: _____

City: _____ Postal Code: _____

Phone: _____ (ext) Fax: _____ Email: _____

Alternate Contact:

Name: _____ Relationship to client: _____

Street Address: _____

City: _____ Postal Code: _____

Phone: _____ (ext) _____ Fax: _____ Email: _____

Form Completed by:

Client: Yes No Primary Contact: Yes No Alternate Contact: Yes No

If none of the above:

Name: _____ Relationship to client: _____

Street Address: _____

City: _____ Postal Code: _____

Phone: _____ (ext) _____ Fax: _____ Email: _____

PHYSICIAN INFORMATION

Referring Respirologist/Physician: _____

Phone: _____ (ext) _____ Fax: _____

Facility: _____ Phone: _____ (ext) Fax: _____

Address: _____

_____ Postal Code: _____

Family Physician: _____

Phone: _____ (ext) _____ Fax: _____

Address: _____



**PROVINCIAL RESPIRATORY OUTREACH PROGRAM
AUTHORIZATION TO ACCESS AND DISCLOSE INFORMATION**

Technology For Living works co-operatively with other agencies on behalf of the client and in the best interest of the client. In order to work effectively with these agencies, the Technology For Living representative will on occasion need to correspond, either in written or verbal form, with that agency only as it relates to the individuals' respiratory care.

I, _____, hereby authorize the Technology For Living and/or its representatives to release or obtain from such agencies, individuals, medical centres or hospitals as are concerned with my care, any and all pertinent information which may be necessary to assist in providing me with respiratory related services.

I also consent to:

- Visits by a Technology For Living representative (ie. Respiratory Therapist)
- A Technology For Living representative attending meetings, specifically regarding my care and/ or discharge planning
- A Technology For Living representative acting as a community resource
- Would like to be contacted by Peer Support Group
- Would not like to be contacted by Peer Support Group

I have been informed of all the reasonably foreseeable disclosures of information, including to third party payers such as insurance companies, and understand and agree that these disclosures are made by Technology For Living with my permission. When such disclosures are in writing, I will be sent a copy. This release is in effect only as long as my file remains open and active with the Technology For Living.

Any personal information received by The Technology For Living is protected under the Personal and Business Conduct Policy (1996) and the Freedom of Information and Protection Privacy Act.

SIGNATURE: _____ DATED THIS _____ DAY OF _____ 20____

CLIENT FIRST NAME: _____ LAST NAME: _____

THE FOLLOWING TO BE COMPLETED BY WITNESS IF ABOVE SIGNED WITH AN "X" OR BY CLIENT REPRESENTATIVE IF CONSENT IS MADE ON CLIENT'S BEHALF:

FIRST NAME: _____ LAST NAME: _____ PHONE : _____

SIGNATURE: _____ RELATIONSHIP TO CLIENT: _____ DATE: _____