ONTARIO MIDWIFERY PROGRAM
Client Consent to Release Personal Information

To:	**Uxbridge Community Midwives**	**(the "Practice Group")**
And to:	**Markham Stouffville Hospital**	**(the "Transfer Payment Agency")**
And to:	**The Ministry of Health and Long-Term Care**	**(the "Ministry")**

In order to enable the Transfer Payment Agency and the Ministry to administer, monitor and evaluate the Midwifery Program in Ontario **I agree to allow** the Practice Group to provide, at any time during or after my midwifery care, the following information to the Transfer Payment Agency and the Ministry:

1. my health card number, if I have one; and
2. my infant's health card number, if I receive one.

I also understand that the following information will be provided to the Ministry and the Transfer Payment Agency for the purpose verifying the services the Practice Group provided to me:

3. my postal code;
4. my birth date;
5. my booking date, due date and discharge date;
6. the number of visits I have with the Practice Group;
7. the dates of my visits with the Practice Group;
8. the clinical services I (or my infant) receive from the Practice Group and the clinical outcomes and location of those services;
9. whether the Practice Group referred me to a physician for any services during my midwifery care; and
10. the number and kind of services I received from the physician as a result of the referral by the Practice Group.

I acknowledge that the Practice Group has explained the content and purpose of this consent form to me and that I have had my questions answered to my satisfaction.

I understand that I may give or withhold my consent to the disclosure of my, or my infant's, health card number. I understand that the Practice Group is required to provide other information about my care to the Transfer Payment Agency or the Ministry. I understand that the Transfer Payment Agency or Ministry may contact me for further information, if necessary.

_____

Name

_____

Signature

_____

Date