BRIDGEPOINT
FAMILY HEALTH TEAM
active healthcare

CONSENT TO SHARED CARE

I, _____, D.O.B _____,

hereby understand and consent to shared care management by multiple health professionals in the Bridgepoint Family Health Team. My medical records, including clinical notes from any of the health professionals who have treated me in the Bridgepoint Family Health Team will be considered as a single record of my care in the Bridgepoint Family Health Team, and may be viewed by any member of the Family Health Team.

My records may be transmitted in full to other parties outside the Bridgepoint Family Health Team upon valid request and with my specific written consent. No records, personal or medical information will be released to any third party without my specific written consent except as required by law.

_____ _____

Signature of Patient/Client Date

_____ _____

Signature of Witness Date