



DUAL DIAGNOSIS ALTERNATE LEVEL OF CARE COLLABORATIVE CLINIC
CONSENT TO DISCLOSURE, TRANSMITTAL, EXAMINATION AND STORAGE OF HEALTH INFORMATION

I, _____, hereby understand that:

(Name of person referred)

- The DD ALC Collaborative Clinic provides a **one-time consultation service** and does not replace ongoing care from my medical or clinical support team.
- The clinical professional team involved in the clinic **will not assess or treat me directly** but instead **provide recommendations to my team**.
- Recommendations are based on the information available to the team at the time of the consultation and are designed to support my existing team to meet my needs.
- The referring team must take ownership for implementing and monitoring the consultation team's recommendations.
- This service does not replace ongoing assessment, treatment, or primary care services from the individual's existing healthcare providers.
- I consent to my personal health information being shared with the DD ALC Collaborative Clinic clinical professionals for the purpose of providing recommendations.
- I understand that my information will be handled in accordance with the Personal Health Information Protection Act and applicable privacy and confidentiality requirements. My health information will be stored securely at Canopy Support Services, a member agency of SCDSN.

This consent is valid from the period of _____ to _____ (one year)
*(dd-mmm-yyyy)**(dd-mmm-yyyy)*

☐ In respect of myself (please check)

OR if signed by a substitute decision maker,

☐ In respect of _____ DOB: _____
*(name of client)**(date of birth as dd-mmm-yyyy)*

I understand the nature of the services being provided as they have been explained to me and am voluntarily agreeing to participate in the DD ALC Collaborative Clinic.

Signature of Person Referred _____ Date _____

Signature of Substitute Decision Maker _____ Date _____

Signature of Witness _____ Date _____