BOOST™
CHILD & YOUTH ADVOCACY CENTRE

AUTHORIZATION TO OBTAIN, DISCLOSE AND/OR RELEASE PERSONAL INFORMATION

The goal of Boost Child & Youth Advocacy Centre (Boost CYAC) is to provide a comprehensive, coordinated response to children, youth and families when abuse is reported. Professionals at Boost CYAC work together as a Multidisciplinary Team (MDT) to ensure that you and/or your family receive the support and service(s) that are needed.

The MDT at Boost CYAC is made up of professionals from partner agencies that work together to provide investigation, medical evaluation, advocacy, counselling and support, and court preparation services, following a report or investigation of abuse. In order to provide you and/or your family with the best care in the most efficient and timely manner possible, it is necessary for members of the team to share information about you and/or your family with each other. The sharing of this information helps us make decisions about the care that you and/or your family may need.

Members of the Boost CYAC team require consent from families (parents/legal guardians, and children/youth 12 years of age and older) to share information with each other. The decision to provide consent is yours to make. If you choose not to sign the consent, each member of the team will continue to provide services to you and/or your family, but they will not be able to share information with one another while they do so except as permitted or required by law. If you have any concerns or there is anything about this Consent and Authorization that you don't understand, please ask for clarification.

CONSENT AND AUTHORIZATION TO OBTAIN, DISCLOSE AND/OR RELEASE PERSONAL INFORMATION

I, _____ authorize Boost Child & Youth Advocacy Centre, Children's Aid Society of Toronto, Catholic Children's Aid Society of Toronto, Hospital for Sick Children (SickKids), Toronto Police Service and _____[add other partner agencies if applicable] and their employees and representatives to share information about me and my children identified below with each other for the purpose of completing their investigations and providing me and/or my family with medical evaluation, advocacy, counselling and support, and court preparation services, as required.

My full name: _____ Date of birth:_____

Child's name:____ _____ Date of birth: _____

Child's name: _____ Date of birth: _____

Child's name: _____ Date of birth: _____

Signature: _____ Date: _____

[To be completed at a later date if needed]

I, _____ authorize the agencies set out above to share information about me and my children named above with the following additional agencies

_____

and I authorize these additional agencies to share information with the other CYAC agencies authorized initially, all for the purposes of providing me and/or my family with medical evaluation, advocacy, counselling and support, and court preparation services, as required.

Signature: _____ Date: _____