



## NEAR NORTH PALLIATIVE CARE NETWORK

2025 Main Street West, North Bay, ON, P1B 2X6

Phone: 705-497-9239 1-800-287-9441 Fax: 705-497-1039

Sturgeon Falls: 705-753-3110 ext. 339

E-mail: [office@nnpcn.com](mailto:office@nnpcn.com)

Website: [www.nnpcn.com](http://www.nnpcn.com)

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### CLIENT CONSENT TO OBTAIN AND RELEASE INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
M/D/Y

Address: \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize the Near North Palliative Care Network (N/PS) to  
**obtain** for their records, any information necessary for the care of  
\_\_\_\_\_ and to **release** this information to Near North Palliative Care  
Network (Nipissing/Parry Sound) team members and other service providers.

I am aware that I may cancel or amend this consent in writing at any time.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Client**

Or

\_\_\_\_\_  
**Person Authorized to Sign  
On Behalf of Client**

**Confidentiality.** The information contained in this communication is private and confidential, intended only for the named recipient(s). If received in error, please notify the sender by telephone immediately and keep the information in a secure manner until further direction is given by the sender. Do not copy the information or disclose it to any other person.