

CONSENT TO THE DISCLOSURE OF PERSONAL HEALTH AND SOCIAL SERVICES INFORMATION TO SYSTEM NAVIGATOR

You have requested that the Department of Health and Social Services' **System Navigator** assist you in resolving a problem which will require access to your personal information. This consent form will allow the Deputy Minister of Health and Social Services (and their officials and departmental representatives) to review this matter on your behalf.

I, _____, of
(Print Your Full Name)

(Print Your Address, Community, Postal Code)

born on _____, **authorize:** (Check all that apply below.)
(DD/MM/YYYY)

- Beaufort-Delta Health and Social Services Authority
- Dehcho Health and Social Services Authority
- Fort Smith Health and Social Services Authority
- Hay River Health and Social Services Authority
- Sahtu Health and Social Services Authority
- Stanton Territorial Health Authority (including Stanton Medical Travel)
- Tłı̄chǫ Community Services Agency
- Yellowknife Health and Social Services Authority
- Department of Health and Social Services (including Health Services Administration)

to disclose my personal information about this specific issue/incident:

- Medical Travel
- Health Care Card
- Health Benefits Coverage (prescription drugs, vision, dental, etc.)
- Doctor/Nursing Services (plan of care)
- Long Term Care
- Other _____

(Use separate piece of paper if needed.)

I understand that this consent is limited to this particular issue. I may be asked to provide additional consent if I request the System Navigator to review another matter on my behalf.

Signature of Patient/Client: _____ Date: _____
(Signature) (DD/MM/YYYY)

Name of Witness: _____
(Print Name Here)

Signature of Witness: _____ Date: _____
(Signature Here) (DD/MM/YYYY)

Expiry Date of Consent: _____ (One year from date of signature or less.)
(DD/MM/YYYY)