New Directions for Children, Youth, Adults and Families
Multi-Disciplinary Assessment and Consultation Centre (MACC)

Consent to Receive Services and Exchange of Information

_______________________________ (name) has been referred to the Multi-Disciplinary Assessment and

Consultation Centre (MACC). Date of Birth is:______________________________________

By signing below, there is an agreement for:

- The above individual to receive requested services from MACC (Consultation, Therapy and/or Assessment)
- MACC consultants to exchange information or consult with significant others and/or other service providers **if needed and when relevant** to support the individual (please list those that are applicable).
- Services may be provided by Registered health professionals (i.e., Psychologist, Psychiatrist, Social Worker, Family Therapist, or Occupational Therapists), senior students/candidates working under the supervision of a Registered professional, or Knowledge Keeper as applicable

Examples of persons/places with whom to exchange information:

- ***Significant others*** (e.g. parents, legal guardian, partner, children, etc.);
- ***Direct service providers*** (e.g. Foster parents, School, Daycare, Doctor, New Directions' services);
- ***Funder*** (e.g. Children's DisAbility Services, Community Living Disability Services, Child and Family Services, Employment Income Assistance, Victim's Services, Winnipeg Regional and Health Authority, Jordan's Principle, NIHB/IRS, insurance company, individual);
- ***Health Services*** (e.g. Psychology, Occupational Therapy, Psychiatric Nursing, Psychiatry, Pharmacy, Speech & Language Pathologist);
- ***Other*** (e.g. Action Therapist, Justice, etc.)
- ***None***

Please list who you will give consent to exchange information :

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Information released or gathered will be handled according to governmental standards of privacy protection.
If the individual receiving services is a minor:
I, we, understand that the specific content of the sessions between the above-named minor and MACC will remain confidential and that the client has the right to request that some information about his/her assessment not be shared with me/us.

I/we also understand that any information indicating danger to my child will be reported to me/us as legal guardian/parent and/or a Child and Family Service Agency as deemed appropriate.

This Consent will expire one (1) year from the date signed unless otherwise specified below.

Signature: ______________________________
(Please circle appropriate category: Self, Parent, Guardian, and Substitute Decision Maker)

Witness: ______________________________

Date signed: __________________________

Date of Expiry: ________________________
(if not one year)