COMMUNITY ORAL HEALTH SERVICES (COHS) AUTHORIZATION

Privacy statement

The collection, use and disclosure of personal information as a part of Indigenous Services Canada's (ISC) Community Oral Health Services program is authorized under Section 6 of the *Department of Indigenous Services Act* (https://laws.justice.gc.ca/eng/acts/i-7.88/page-1.html), and is in accordance with the requirements of *Privacy Act* (https://laws-lois.justice.gc.ca/eng/acts/P-21/index.html). Information collected will be used exclusively as documentation for client treatment, as well as for program reporting and evaluation. The collection, use and disclosure of your personal information is required for your participation in the Program. Personal information will be retained pursuant to the *Privacy Act* and its *Regulations*. The collection of information is described in the departmental Personal Information Bank for Community Oral Health Services (PPU 008) available online at https://www.sac-isc.gc.ca/eng/1639748667069/1639748703555#chp06. Individuals have the right to the protection of, access to and request the correction of their personal information under the *Privacy Act*. If you require clarification concerning the Privacy Notice Statement, please contact the Departmental Access to Information and Privacy Office at 1-819-997-8277 or by email at upvp-ppu@sac-isc.gc.ca. For more information on privacy issues, your right to file a complaint and the *Privacy Act* in general, you can consult the Privacy Commissioner at 1-800-282-1376.

► **To be completed by parent, guardian or authorized representative if the client is a minor** (use block letters)

Client's legal family name	Given name	Date of birth (YYYYMMDD)

Sex at birth	Gender identity	Gender pronouns	Registration/Treaty or 'N' number (9 or 10 digit number)
◯ Male ◯ Female ◯ Other			

Address (Number / street / apartment / P.O. box, city or town, province/territory, postal code)	Community

By signing below I,

(a) Give my authorization for client (named above) to receive any of the following oral health services *(select below)*:

- ☐ Oral screening
- ☐ Oral health information sessions
- ☐ Dental sealant applications (if required)
- ☐ Fluoride varnish applications
- ☐ Temporary fillings ART or IST (if required)
- ☐ Silver diamine fluoride (if required)

► Complications or reactions to these procedures are unusual. However, if the client has any complications or reactions to these services, please contact a nurse or oral health professional.

(b) Give my authorization for The Government of Canada to collect, use and disclose information about the client for the purposes of the Community Oral Health Services;

(c) Give my authorization for The Government of Canada to access the client's pandemic/epidemic screening results, obtained by partner organizations, for the purposes of meeting Dental Regulatory Authorities & Provincial/Territorial Associations' screening criteria, pursuant to section 4 of the *Privacy Act*;

(d) Understand that the personal information of the client is protected under the *Privacy Act* and the information may only be used or disclosed within the conditions set out in the *Privacy Act*;

(e) Understand that oral health program records and data information may be used by the Government of Canada, for management and administration purposes only directly related to the Community Oral Health Services;

(f) Confirm that I have read and understand the content of this authorization form;

(g) Choose to give my consent voluntarily; and

(h) Understand that this consent will remain in effect until it is withdrawn in writing by a parent, guardian or authorized representative of the above-named client.

► **Consenting person's information if the client is a minor (parent, guardian, substitute decision maker, person having a legally recognized authority to act on behalf of the client).**

Given name	Family name	Telephone number

Relationship to client	Community

Address (Number / street / apartment / P.O. box, city or town, province/territory, postal code)

► **Client authorization**

Signature	Date (YYYYMMDD)