Halton Hills
Family Health Team

INFORMED CONSENT TO ASSESSMENT AND TREATMENT

I (we) have reviewed *Health Educator/Navigator Client Information Form* and understand the policies relating to the HHFHT services, including the cancellation policy, and the limits to confidentiality. My (our) signature(s) below indicate that I (we) accept their policies.

I (we) understand the meaning of "*informed consent"* and agree to request clarification if I (we) ever have any questions about the support process, the procedures, and/or anticipated outcomes.

I (we) understand that I am (we are) free to stop the support process for any reason at any time.

Print Client Name	Signature of Client/Guardian	Date
Print Name	Signature of Client/Guardian	Date
Print Name	Signature of Client/Guardian	Date
Witness Name	Signature of Witness	Date
Emergency Contact (Relationship)		Phone

Ontario