Client Consent Form

TO: Thames Valley Midwives
("the Practice Group")
AND TO: London Health Sciences Centre
("the Transfer Payment Agency")
AND TO: The Ontario Midwifery Program of the Ministry of Health and Long-Term Care
("The Ministry")

☐ I have been informed by, and hereby give my consent to this Practice Group, to collect, use, and disclose my personal information for the purposes of providing me with midwifery services. I understand that the Practice Group may share all or some of this personal information with its service providers and other health-care providers and organizations on a "need-to-know" basis where required for my health care.

☐ I also give my consent to the Practice Group to provide the following information to the Transfer Payment Agency and to the Ministry:

- My health card number
- My infant's health card number, if applicable
- My booking date and the number of visits I have with my midwives
- The dates, type and location of services I receive from the midwives, and the clinical outcomes of those services, and
- Physician services provided to me during my course of care.

I understand that the Practice Group, the Transfer Payment Agency, and the Ministry may use this information for the specific purpose of learning more about the services of this Practice Group, and more generally, for gathering information about the provision of midwifery services in Ontario.

_____
Name

_____
Signature

_____
Health Card Number Version Code

_____
Date of Birth (dd/mm/yyyy)