Consent to Disclose Personal Health Information

Pursuant to the Personal Health Information Protection Act, 2004(PHIPA)

I, _____, authorize _____

to disclose

☐ my personal health information consisting of:

_____

_____

(Describe the personal health information to be disclosed)

or

☐ the personal health information of _____

(Name of person for whom you are the substitute decision maker)

consisting of:

_____

_____

(Describe the personal health information to be disclosed)

to _____

(Print name and address of person requiring the information)

I understand the purpose for disclosing this personal health information to the person noted above. I understand that I can refuse to sign this consent form. I understand that I may withdraw my consent.

My Name: _____ Address: _____

Home Tel.: _____ Work Tel.: _____

Signature: _____ Date: _____

Witness Name: _____ Address: _____

Home Tel: _____ Work Tel: _____

Signature: _____ Date: _____

* Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.