## Consent to Disclose Personal Health Information <u>Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)</u>

|  | , authorize  |
|--|--|
| (Print your name)  | , authorize, (Print name of health information custodian)  |
| to disclose  |  |
| □ my personal health infor   | mation consisting of:  |
|  | -  |
|  |  |
| (C) 11 11 11 12 12 13 13 13 13 13 13 13 13 13 13 13 13 13  |  |
| (Describe the personal health informat   | ion to be disclosed)   |
| or   |  |
|  | mation of  |
| ine personal nearth infor  | (Name of person for whom you are the substitute decision-maker*)   |
|  |  |
| consisting of:   |  |
|  |  |
| (Describe the personal health informat   | ion to be disclosed)   |
|  |  |
|  |  |
| (Print name and address of person  | requiring the information)   |
| (Print name and address of person  | requiring the information)   |
|  |  |
| I understand the purpose i   | requiring the information)  For disclosing this personal health information to the person that I can refuse to sign this consent form. |
| I understand the purpose i   | or disclosing this personal health information to the person   |
| I understand the purpose f<br>noted above. I understand  | For disclosing this personal health information to the person that I can refuse to sign this consent form.                             |
| I understand the purpose for the noted above. I understand My Name:                                    | For disclosing this personal health information to the person that I can refuse to sign this consent form.  Address:                   |
| I understand the purpose for the noted above. I understand My Name:                                    | For disclosing this personal health information to the person that I can refuse to sign this consent form.                             |
| I understand the purpose to noted above. I understand My Name:  Home Tel.:                             | For disclosing this personal health information to the person that I can refuse to sign this consent form. Address:                    |
| I understand the purpose to noted above. I understand My Name:  Home Tel.:                             | For disclosing this personal health information to the person that I can refuse to sign this consent form.  Address:                   |
| I understand the purpose of noted above. I understand  My Name:  Home Tel.:  Signature:                | For disclosing this personal health information to the person that I can refuse to sign this consent form.  Address: Work Tel.: Date:  |
| I understand the purpose of noted above. I understand  My Name:  Home Tel.:  Signature:                | For disclosing this personal health information to the person that I can refuse to sign this consent form. Address:                    |
| I understand the purpose to noted above. I understand  My Name:  Home Tel.:  Signature:  Witness Name: | For disclosing this personal health information to the person that I can refuse to sign this consent form. Address:                    |
| I understand the purpose to noted above. I understand  My Name:  Home Tel.:  Signature:  Witness Name: | Or disclosing this personal health information to the person that I can refuse to sign this consent form.  Address:                    |

\*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.