Consent to Disclose Personal Health Information

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

I, _____, authorize_____
(Print your name) *(Print name of health information custodian)*

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.

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.**