Consent to Disclose Personal Health Information

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

I, Darryl Ross, authorize Shagrow Francis Harrison
(Print your name) *(Print name of health information custodian)*

to disclose

~~☐~~ ☒ my personal health information consisting of:

Anything + everything + but in particular, information/findings about Charlotte

(Describe the personal health information to be disclosed)

~~or~~ And

~~☐~~ ☒ the personal health information of Charlotte Holmes
(Name of person for whom you are the substitute decision-maker)*

consisting of: Anything that deems pertinent (or can make available)
(Describe the personal health information to be disclosed)

to – Me (768 Mayfly Cres. Ottawa K2J 6C7
– Any Mayer (112 Lisgar St. Ottawa K2P 0C2
– Cynthia Holmes (221 Bramblewalk, Ottawa K2J 0E4)
(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: Darryl Ross **Address:** 768 Mayfly Cres

Home Tel.: 613 762 2067 **Work Tel.:** 613-727-4723 x6402

Signature: [signature] **Date:** 07/28/16

Witness Name: Larissa Scott **Address:** 7701 Fairhurst Dr

Home Tel.: 808-7650 **Work Tel.:** _____

Signature: [signature] **Date:** 28/07/16

***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.**