The Children's Aid Society of Ottawa | La Société de l'aide à l'enfance d'Ottawa

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

I, Darryl Ross, **authorize** Carol Milstone
(Print your name) *(Print name of health information custodian)*
to disclose
☐ my personal health information consisting of:
OUR COUNSELLING SESSIONS
(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 Heather Clark 150 Katimavik Rd Ottawa ON K2L 2N2
(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:** 468 Viaduct Cres
Home Tel.: 613 762 2067 **Work Tel.:** —
Signature: [signature] **Date:** May 5 2017

Witness Name: Amy Mayr **Address:** 112 Lisgar Street, Ottawa/Ont.
Home Tel.: _____ **Work Tel.:** (613) 238-1333
Signature: [signature] **Date:** 5/5/2017.

*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.