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 of person requiring the information)

Address: _____

(Print address of person requiring the information)

City: _____ **Postal Code:** _____

☐ **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: _____

City: _____ **Postal Code:** _____

Home Tel.: _____ **Work Tel.:** _____

Signature: _____ **Date:** _____

Witness Name: _____

Address: _____

City: _____ **Postal Code:** _____

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.**