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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)

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:**____