

**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.**