Convenient Confidential Counseling

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

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

I, ____
(print name)

hereby authorize ____
(name of health information custodian)

to disclose the following personal health information: _______________________________

____

____

To: ____
(name of person or organization requiring / requesting the information)

Address: ____

From the health records of:

Name of Patient: _________________________________ Date of Birth: ___________

Address: ____

____

I understand the purpose for disclosing this personal health information to the person or organization noted above. I understand that I can refuse to sign this consent form.

Signature: ______________________________ Date:______________________
(patient or substitute decision maker*)

Print Name:______________________________Telephone:___________________

Relationship to Patient: ____
(if signed by substitute decision maker*)

Witness: ______________________________ Date:______________________
(witness signature)

Print Name:______________________________

*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.