Upper Grand
Family Health Team

Patient 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 (print): ________________________ Address: ______________________________

Home telephone: ________________________ Work telephone: ________________________

Signature: ______________________________ Date: __________________________________

Witness Name (print): ____________________ Address: ______________________________

Home telephone: ________________________ Work telephone: ________________________

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.