**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: (Diagnosis, medical conditions, physical and mental health history and any relevant information we should be made aware 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: (Diagnosis, medical conditions, physical and mental health history and any relevant information we should be made aware of.)
**Describe the personal health information to be disclosed.**

**To:** Sandie Heirwegh, Executive Director, True Experience Supportive Housing and Community Work Program, 201 Forest St. E., Dunnville, ON N1A 3G5
Tel: 905-774-6165; Fax: 905-774-4620 email: sandie@trueexperience.ca

**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.**