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: Eve Roorda/ Jillian Spencer, True Experience Supportive Housing and Community Work Program, 201 Forest St. E., Dunnville, ON N1A 3G5 Tel: 905-774-8691 Fax: 905-774-4620

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.**