Centre for Life Solutions

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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 the 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: ______________ Expiry 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.