

**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:** \_\_\_\_\_ **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.**