

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: SUMMIT HOUSING & OUTREACH PROGRAMS
871 Equestrian Court, Unit 7
Oakville, ON L6L 6L7

(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.**
***** THIS FORM WILL REMAIN IN EFFECT FOR ONE YEAR. Consent may be revoked at any time by contacting a member of Summit staff.**