MAPLETON
HEALTH CENTRE

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Consent to Disclose Personal Health Information
Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

Section A

My Name: _____ Address: _____

Primary Tel: _____ Secondary Tel: _____

I authorize the Mapleton Health Centre to disclose the following information in regards to myself:

- ☐ All information
- ☐ Appointment Information Only
- ☐ Tests or Lab Results
- ☐ Assessment Report
- ☐ Summary Report
- ☐ Consultation about Treatment

To: _____ _____ _____
(Name) (Relationship) (Contact telephone #)

☐ Ok to leave message on Voice Mail

Section B (Child under 16 and/or dependent adult)

My Name: _____ Address: _____

Primary Tel: _____ Secondary Tel: _____

I authorize the Mapleton Health Centre to disclose the following information in regards to myself:

- ☐ All information
- ☐ Appointment Information Only
- ☐ Tests or Lab Results
- ☐ Assessment Report
- ☐ Summary Report
- ☐ Consultation about Treatment

To: _____ _____
_____
(Name) (Relationship) (Contact telephone #)

☐ Ok to leave message on Voice Mail

** 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. I waive any and all claims against the Mapleton Health Centre's office in connection with the disclosure of this personal health information.

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.