TRENT HILLS FAMILY HEALTH TEAM

Consent to Disclose Personal Health Information

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

I, _____, authorize Trent Hills Family Health Team to disclose
(Print your name)

☐ 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)

Telephone Number: _____

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: (must not be the same person as the recipient of the health information)

Name: _____ Address: _____

Home Tel.: _____ Work Tel.: _____

Signature: _____ Date: _____

* 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. Proof of Power of Attorney for Personal Care must be attached to this document.