Dawson Heights Medical
109-109 Regina Avenue
Thunder Bay, ON P7B 5B4

Consent to Communicate Information to an Authorized Person

This form allows you to name a person (such as your spouse, partner, other family member or friend) to communicate on your behalf with the doctor pertaining to certain aspects of your medical care.

I, _____ hereby give my consent for an agent to act on my behalf with regards to certain aspects of my care.

Agents Name: _____
Address: _____
City:_____ Province:_____
Phone Number: _____
Relationship to Patient:_____

1) I authorize this person to receive phone messages or letters from the doctor on my behalf.
Yes (initial)_____ No (initial) _____

2) I authorize this person to book/cancel/change appointments with the doctor on my behalf.
Yes (initial)_____ No (initial) _____

3) I authorize this person to receive test results on my behalf, including (but not limited to) lab and diagnostic imaging results, as well as discuss or receive prescriptions.
Yes (initial)_____ No (initial) _____

I understand that I have the right to revoke the access of my agent (as above) to my medical care at any time.

Patient Signature: _____ Date:_____
Witness Signature: _____ Date:_____