Consent to Disclose Personal Health Information

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

If the patient is signing for themselves:

I (Patient name) authorize (Pharmacy name) to disclose my personal health information.

If a substitute decision maker* is signing on behalf of the patient:

I (Representative name) authorize (Pharmacy name) to disclose the personal health information of (Name of person for whom you are the substitute decision maker).

TO

BlendRx
150 Britannia Road East Units 23 & 24
Phone: 905-203-3001
Fax: 1-833-527-6565

I understand the purpose of disclosing personal health information to BlendRx and I understand that I can withdraw consent at any time.

_____ Signature

_____ Date

Pharmacy Section Only

Staff Witness Name:

Staff 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.
Information to be disclosed: Name, date of birth, contact information (address, phone number, email address), medical conditions, medication history, drug allergies, health insurance information.