Consent and Authorization to Disclose Personal Health Information

Pursuant to the Personal Health Information Protection Act. (PHIPA)

From:

Patient's Name	
Phone number	
Health card number	
Date of Birth	

To:

Health care provider's name	
Address	
Fax	
Phone	

Hereby, I authorize you to release my personal health information

Entirely					
Partly	Consultations	lab reports	DI reports	Chart notes	etc

To:

Dr. Mostafa Ranji, MD, CCFP
100B - 1801 Eglinton Ave West, Toronto, M6E 2H8
Tell: (416) 657-1321

Via:

Fax number **(416) 657- 8482**	
Password protected email	
Via a memory stick	
Mail (paper copy)	

Please contact me directly at above phone number should you require an administrative fee for this service; as it is not covered by OHIP.
I understand that it's my responsibility to follow up with your office for timely transfer of my records to avoid any possible delays with my medical care.

Sincerely,

Patient's Signature:

YYYY-MM-DD: