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

☞ *Fill this section out if you are the patient*

I, _____, authorize _____
(Print your name) *(Print name of Family Doctor)*

to disclose

☐ my personal health information compiled at the Caroline Medical Group consisting of:

_____

(_____

Describe the personal health information to be disclosed)

or

☐ all personal health information in my Caroline Medical Group chart dated between _____ and _____ (inclusive)
(Date) *(Date)*

Date of Birth: *Telephone:*

Address:

Signature: *Date:*

☞ *Fill out this section only if you are the substitute decision-maker* for the patient*

☐ the personal health information of _____
(Name of person for whom you are the substitute decision-maker)*

compiled at the Caroline Medical Group consisting of: _____

_____

(Describe the personal health information to be disclosed)

or

☐ All personal health information in my Caroline Medical Group chart dated between _____ and _____ (inclusive)
(Date) *(Date)*

Patient's Date of Birth: Patient's Telephone:

Patient's Address:

Decision-Maker's Name: Relationship to Patient:

Signature: Date: Your Telephone:

Release this information to: _____

_____

(Print name and address of person requiring the information)

I understand the purpose for disclosing this personal health information to the person/institution noted above. I understand that I can refuse to sign this consent form.

Witness Name: _____ Witness Signature: _____

A substitute decision-maker is a person who has written authorization to consent, on behalf of an individual, to disclose personal health information about the individual and they must have proof of this authorization. If you are a substitute decision-maker signing this consent, your relationship to the patient **must be stated.*