Consent to Disclose Personal Health Information

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

I, ____________________________, **authorize** Kidcrew Medical Fax 647-689-2371
(Print your name) *(Print name of health information custodian)*

to disclose

☐ 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)

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 Name:_____________________**Address:**____________________________________

Home Tel.:________________________**Work Tel.:**___________________________________

Signature:_________________________**Date:**_______________________________________

***Please note: 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.**