# Consent to Disclose Personal Health Information

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

I, ______________________________________________________________

(Your Name/Name of substitute decision maker)

**Authorize:**

_______________________________________________________________

(Name of previous Doctor, Nurse Practitioner, Clinic, Etc.)

Information to be released:

- ☐ Summary of my medical records
- ☐ The most recent two years of pertinent medical information (Chart notes, labs, x-rays and other tests, consultant reports)
- ☐ All Medical records
- ☐ Specific Information: __________________________________________

  __________________________________________

  __________________________________________

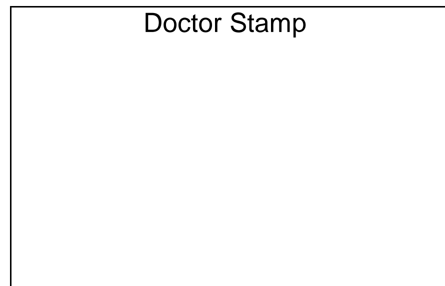
**TO:** Dr. ____________________________________________________

(Name of Doctor requesting health information and Address of institution)

**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.**

Name: _________________________ Signature:__________________________

Date: _________________

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Witness Name: _____________________ Signature:_______________________

**Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual or to disclose personal health information about the individual.