DUNCAN FAMILY DOCTORS

NORTH YORK FAMILY HEALTH TEAM

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

I, _____ **, authorize** _____

(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 the consent form

Name _____ **Date of Birth** _____ **OHIP** _____

Contact Number _____ **Email** _____

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**