North Eastern Ontario
Family and Children's Services
Services à la famille et à l'enfance
du Nord-Est de l'Ontario

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

File No. _____

I, _____, D.O.B: _____ **authorize**
(Print your name) *(Your date of birth)*

_____
(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: _____ D.O.B: _____
(Name of person for whom you are the substitute decision maker)[i] *(Their date of birth)*

consisting of:

_____
(Describe personal health information to be disclosed)

to

_____
(Print name and address of person requiring the information)

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

My Name: _____

Address: _____

Tel. (Home): _____ Tel.(Work): _____

Signature: _____ Date: _____

Witness Name: _____

Address: _____

Tel. (Work): _____

Signature: Date:

Distribution:	
Expiry Date:	Maximum of one year
Original:	Client File
Copy(ies)	

[i] **Please note:** A substitute decision-maker is a person authorized under the Personal Health Information Protection Act (PHIPA) to consent, on behalf of an individual, to disclose personal health information about the individual