# CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I, _____, authorize:

Name of clinic/doctor: _____

Address: _____

Phone number: _____ Fax number: _____

**to disclose to 1CLINIC:**

☐ my personal health information consisting of:

_____

(Describe the records to be disclosed; if you'd like all records to be release, please write ALL RECORDS)

_____

☐ the personal health information of _____

(Name of person for whom you are the substitute decision-maker*)

_____

(Describe the records to be disclosed; if you'd like all records to be release, please write ALL RECORDS)

_____

I understand the purpose for disclosing this personal health information to 1CLINIC and I understand that I can refuse to sign this consent form.

My Name:_____ Health Card Number: _____

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.

***** USB PENS AND CDS ARE NOT ACCEPTED *****

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