Consent to Disclose Personal Health Information

Pursuant to the Personal Health Information Protection Act, 2004 [PHIPA]

I, ______________________________, authorize ____________________________________ to
(Print your name) (Print name of health information custodian)

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:

Dr. Norman Goldberg
43 Goldthorne Avenue
Toronto, ON
M8Z 5S7
Canada

Fax: 1-844-615-5262

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

My 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.**

MINISTRY OF HEALTH AND LONG-TERM CARE