Consent For Release of Information (Request) Form

By completing and signing this form, you are consenting to disclose personal health information, <u>pursuant to the Personal Health Information Protection Act, 2004 (PHIPA).</u>

I, _____, authorize the **MUSHKEGOWUK COUNCIL**, to request and receive:

My personal health information, consisting of *(please describe the health related information to be disclosed):*

_____

_____

_____

<u>OR</u>

The personal health information of _____, for whom I am the substitute decision-maker*, consisting of *(describe the health related information to be disclosed):*

_____

_____

_____

<u>FROM</u>:

_____

(Person and/or Agency you want us to receive your information from – this gives permission to disclose)

ADDRESS:

_____

TELEPHONE: _____

FAX:_____

*<u>Please note:</u> 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.

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NOTICE (If you agree, please check each box):

☐ If I have questions about my choices about sharing personal health information, I understand I can ask questions before I sign this

☐ I understand that I can choose to sign this form or choose not to do so – if I choose not to, I will be told what that means

DATE	**NAME**	**SIGNATURE**

To assist with the request, please provide the following:

Client/patient date of birth: _____

Client/patient address: _____

_____

*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.