



Consent For Release of Information Form

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

I, _____, authorize the **MUSHKEGOWUK COUNCIL**, to disclose:

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

OR

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

To:

(Person and/or Agency you want to send the above noted information to – this gives permission to disclose)

ADDRESS:

TELEPHONE: _____

FAX: _____

**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.



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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

My contact information if there are questions

My authority if Substitute Decision-Maker

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.