Box 308 Nipigon, ON P0T 2J0

Phone (807) 887-5252 ext. 2

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CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

1. Patient/substitute decision-maker providing authorization (COMPLETE IN FULL)

PATIENT Full Name:		
Street Address:		Telephone #:
City:	Province:	Postal Code:
Date of Birth:		Patient # (office use only)
I am: ☐ the Patient or ☐ the Substitute Decision-Maker		
Substitute Decision-Maker Name:		☐ DOES NOT APPLY

2. Agency/person REQUESTING my personal health information (COMPLETE IN FULL)

Agency/Person Full Name:		
Street Address:		Telephone #:
Mailing Address (If different from street address):		Fax #:
City	Province	Postal Code

3. Agency/person AUTHORIZED TO RELEASE my personal health information:

☐ The Nipigon District Family Health Team
☐ Other (Please specify):

4. **Please provide the following information:**

Specific description about the type and amount of information to be released:
The intended use of the requested information:

I, the patient, or the patient's substitute Decision-maker, acknowledge and understand the intended use of the above noted information to be release: ☐ YES ☐ NO

I understand that I can refuse to sign this consent form or later withdraw my consent.

Patient Signature: ______________________________ Date: ___________

OR IF REQUIRED:

Substitute Decision-Maker Signature: _______________________ Date: ___________

Address: _____________________________________ Telephone #: _________________

Witness Name: ______________________________

Witness Signature: ____________________________ Date: ___________