Box 308 Nipigon, ON P0T 2J0

Phone (807) 887-5252 ext. 2

Fax (807) 887-5991

SHARING HEALTH INFORMATION WITH A CAREGIVER/FAMILY MEMBER

Please fill in this form so we can share information with your support people as you choose. Please note, if your family member/caregiver is a staff member of the Nipigon District Family Health Team, they will require written consent from yourself, in the form of this document, in order to access your medical record.

Patient providing authorization (PLEASE COMPLETE IN FULL)

Name –		☐Patient is providing VERBAL CONSENT (office use only)
Street Address		Telephone #
City	Province	Postal Code
Date of Birth		Patient # (office use only)

The person listed below is authorized to access my health information:

Name –		☐Patient is providing VERBAL CONSENT (office use only)
Street Address		Telephone #
City	Province	Postal Code
Relationship with patient (eg: spouse, partner, parent, guardian, child, sibling, or other substitute decision-maker)		

The additional person listed below is also authorized to access my health information:

Name –		☐Patient is providing VERBAL CONSENT (office use only)
Street Address		Telephone #
City	Province	Postal Code
Relationship with patient (ie: spouse, partner, parent, guardian, child, sibling, or other substitute decision-maker)		

INFORMATION TO BE RELEASED:

☐ All Information (including telephone/verbal communication)

☐ ONLY for the following subject: _____

☐ ALL information EXCEPT the following subject: _____

This authorization will remain in effect until revoked by you in writing. If you wish to limit the duration of this authorization, please specify end date: _____

Signature of Patient _____ Date: _____

Witnessed/documented by: _____

Witness Signature: _____ Date: _____