Hear at Home LTD.®
MOBILE HEARING CLINIC

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Consent to Disclose Personal Health Information

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I, _____, **authorize** _____

(Print your name) (Print name of health information custodian)

to 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 _____

(Print name and address of person requiring the information)

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

My Name: _____ **Address:** _____

Home Tel.: _____ **Work Tel.:** _____

Signature: _____ **Date:** _____

Witness 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.**