Mamaway Wiidokdaadwin Indigenous
Interprofessional Primary Care Team

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)*

Health Card Number _____ Date of Birth _____

to disclose

☐ my personal health information consisting of:

_____
(Describe the personal health information to be disclose

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.