Consent to Disclose, Transmittal, Access To or Examine Personal Heath Information

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

Authorize Polly Sidher, M.S.W, R.S.W. to disclose personal health information belonging to
____

Date of Birth ____

Concerning treatment from ________________________ to _________________________

____
Personal information to be disclosed includes:
____
____

This information may be disclosed to the following:
____

I understand this personal health information is to be used ONLY by the recipient for the purpose of: ____
____

My Name: _________________________________
Date: _________________________________
Contact Telephone Number: ________________________________
Witness Name: _________________________________
Witness Relationship: _________________________________

Personal Health Information

Signature: _________________________________
Address: _________________________________
Witness Signature: _________________________________
Date: _________________________________