Southwest Ontario Aboriginal Health Access Centre

CONSENT TO RELEASE OR TO OBTAIN INFORMATION

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

I,_____

(Print your name and relationship if you are Parent/ Guardian/ or Substitute Decision Maker)

For_____, **Date of Birth** _____

(Self/ or Name of person) (dd/mm/yyyy)

Address_____**,** and **Phone Number**_____

Do hereby give consent to_____

(Name/Title/ Organization of Health Information Custodian)

TO RELEASE/OBTAIN THE FOLLOWING INFORMATION REGARDING: _____

_____

TO/ FROM _____

(Name/ Title/ Organization)

This information will be used for the following purpose(s):_____

_____

I understand the purpose for disclosing this personal health information, and that I can refuse to sign this consent form or later withdraw my consent.

_____ _____

(Signature of Client, Parent(s), Guardian(s), or Substitute Decision Maker) (Date: dd/mm/yyyy)

_____ _____

(Witness Name, Signature, and Title) (Date dd/mm/yyyy

***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.**

**Should there be any cost levied for this information please contact the Health Centre prior to making any photocopies.

PLEASE NOTE: This Authorization is valid for □ 6 months □ 12 months and pertains to the disclosure of information that is specific to services received on or before the date signed. It can be amended or withdrawn at any time by written notification to Southwest Ontario Aboriginal Health Access Centre. Note: if not designated above, the validation is good for 6 months only.