Southlake Academic
Family Health Team

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

I, ___________________________, authorize the Southlake Family Health Team
(Print your name

to disclose

☐ my personal health information consisting of: (Please Initial, do not √)

_____ Appointment Information _____ Test Results _____ Book Appointments

_____ Leave Detailed Messages on Answering Machine

_____ Pick up Reports/Requisitions/Forms/Scripts

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:_____________________**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.**

It is the responsibility of the Patient to inform the Southlake Family Health Team of any changes to Consent to Disclose Personal Health Information.

NOT TO BE USED FOR SOCIAL WORK DOCUMENTATION