



# Inner City Health Associates

59 Adelaide St. East, 2<sup>nd</sup> Floor

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## Consent to Disclose Personal Health Information

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

I, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
*Print name Health Card # (if applicable) DOB: mm/dd/yyyy*

Authorize: **Inner City Health Associates (ICHA)**

To share my personal health information

OR/

To share the personal health information of \_\_\_\_\_  
*Name of person for whom you are the substitute decision maker*

with

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
*Name of organization/custodian/agency requesting records Address Confidential Fax Number*

### Please send the following records:

**All records (maximum of 50 pages)**  
**Psychiatric Assessments**  
**Last clinical note**

**Discharge Summaries**  
**Medications lists**  
**Lab/Imaging Results**

**Other:**

**Please note ICHA is unable to accept records by compact disc (CD). Please fax or mail a paper copy.**

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

My Name:

Signature:

Date:

Witness Name:

Signature:

Date: