Inner City Health Associates

145 Front Street East, Unit G1
Toronto, ON M5A 1E3
Telephone: (416) 591-4411
Fax: (416) 640-2072

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: