



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:

\_\_\_\_\_  
Name of physician or organization with the records being requested

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 Inner City Health Associates (ICHA)

Please send the following records:

- All records (maximum of 50 pages) Discharge Summaries Other:
Psychiatric Assessments Medications lists
Last clinical note Lab/Imaging Results

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: