Inner City Health Associates

145 Front Street East, Unit G2
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)
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: