Consent to Disclose Personal Health Information

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

I, _____, **authorize** _____

(Print Patient's name) *(Print FULL name of prior Physician AND their phone number please)*

to disclose:

☐ my personal health information consisting of:

(example: "my medical history")

_____

(Describe the personal health information to be disclosed)

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:

Dr. Ricky Sheth: 350 Hwy 7 East, Suite PH 5, Richmond Hill, ON, L4B 3N2

Tel: 905-624-5527 / Fax: 289-870-2010 / Email: admin@drsheth.ca

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:** _____

Tel: _____ **Signature:** _____

Date: _____

Witness Name: _____ **Address:** _____

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.

Acceptable Formats: Dr. Sheth's office cannot transmit/receive records in CD or paper format. We transmit/receive documents by fax, email, and USB only. Please call us if you have any questions or concerns (Sun to Wed, 10am to 6pm). Thank you.