NIPIGON DISTRICT MEMORIAL HOSPITAL

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

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

I, Darlene Wawia (print your name), authorize Nipigon District Memorial Hospital (print name of health information custodian)

to disclose my personal health information consisting of:

Admission to hospital on 19/07/26

(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 Cheyenne Atkinson Health & Wellness Director, RRIB

(Print name and address of person requiring the information)

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

Name: Darlene Wawia

Address: BOX 973, Nipigon, ON, P0T 2J0 Telephone # 807-889-0738

Signature: _____ Date: _____

Witness: _____

September, 2024