CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

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

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

to disclose my personal health information consisting of:

_____

_____
(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

_____
(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: _____

Address: _____ Telephone #_____

Signature: _____ Date: _____

Witness: _____

September, 2024