ST. JOSEPH'S • ST. MICHAEL'S • PROVIDENCE
UNITY HEALTH TORONTO

80236

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION
Pursuant to the Personal Health Information Protection Act, 2004 PHIPA

Patient Name: (last, first)	Date of Birth: (DD/MM/YYYY)
Address:	Health Card Number:
Phone:	Site: Please select one ☐ SJH ☐ SMH ☐ PHC ☐ ALL

☐ I am the Patient ☐ I am the Substitute Decision Maker, Name:_____

Personal health information being requested: (please provide description and dates)

Dates:
Treatments:

Recipient: (Person receiving information, select one)

☐ Self ☐ Lawyer ☐ Insurance ☐ Care provider ☐ Other:_____

Recipient Name:	
Address:	Email:
Phone:	Fax:

Authorization:
In accordance with PHIPA, authorization must be signed by the patient or the substitute decision maker*.

Print: Patient Name/Substitute Decision Maker _____

Print: Name of Witness _____

Signature & Relationship: _____

Signature of Witness _____

Date: _____
(DD / MM / YYYY)

*A substitute decision maker is a person authorized under the Personal Health Information Protection Act to consent, on behalf of an individual, to disclose personal health information about the individual.
Please note that Photo I.D. is required to confirm identity. The consent form is valid for a period of 90 days from the date the form is signed. This authorization shall apply only to the information dated prior to the date of signature.

St. Joseph's Health Centre 30 The Queensway Toronto, ON, M6R 1B5 Tel: 416-530-6047 Fax: 416-530-6046 E: ROI.sjhc@unityhealth.to	St. Michael's Hospital 30 Bond Street Toronto ON M5B 1W8 Tel: 416-864-5213 Fax: 416-864-5831 E: ROI.smh@unityhealth.to	Providence Healthcare 3276 St. Clair Ave. E. Toronto ON M1L 1W1 Tel: 416-285-3666 ext. 4336 Fax: 416-285-3635 E:healthrecordsPHC@unityhealth.to