Release of Information aka Consent to Disclose Personal Health Information Form

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

I, _____, authorize_____
(Print your name) *(Print name of health information custodian)*

to disclose

☐ my personal health information

or

☐ the personal health information of _____
(Name of person for whom you are the substitute decision-maker)*

consisting of (check mark which is applicable):

Medical Summary	Imaging Reports	Imaging CD	Lab reports
Entire Medical Chart	Last encounter note	First encounter note	Immunization Records
Cumulative Patient Profile	Discharge Summary	Transfer Note	Growth Chart
Other (describe below)			

to ZIL-E-HUMA SHEIKH MD, Grow N Blossom Paediatric Clinic, 1671 Howard Ave, Windsor, ON N8X 3T6
Ph: 519-256-4040, Fax: 519-258-2020

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. I understand that there may be a fee I have to pay to comply with my request and am willing to pay any applicable fees to the sender directly.

My Name:_____ Address:_____

Home Tel.:_____Work 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.**