**Consent to Disclose Personal Health Information**

**Pursuant to the Personal Health Information Protection Act 2004 (PHIP)**

**Name**

 First and Last Name

**Date of Birth**

 dd/mm/yyyy

**Address**

 Street, Unit #

 City, Province, Postal Code

**Phone**

[ ]  The above-named individual authorizes those listed below to disclose their personal health information consisting of psychiatric diagnosis and any of the following that may be applicable: criminal activity, violence, incarceration, probation/ parole, suicidal/homicidal ideation/attempts, social work history, vocational assessment, neuropsychological testing results.

 Family Physician:

 Address:

 Pharmacist:

 Pharmacy:

 Address:

 Health Care Provider:

 Organization:

 Address:

 Health Care Provider:

 Organization:

 Address:

**or** [ ]  **the personal health information of**:

 *(Name of person for whom you are substitute-decision maker\*)*

 consisting of:

 *(Describe the personal health information to be disclosed)*

**to** IntAc – Intensive Case Management Access Coordination

(Canadian Mental Health Association - Hamilton Branch, Community Health Promotion Program – City of Hamilton, and Hamilton Program for Schizophrenia)

**I understand the purpose of disclosing this personal health information to the agencies noted above is to determine my eligibility for case management services. I understand that I can refuse to sign this consent form.**

My Name:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Witness Name:

Address:

Relationship to Applicant:

Phone:

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.**

*rev. May 1, 2023*

Arp

**r**