**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*

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