IntAc
Intensive Case Management Access Coordination
131 John Street South, Hamilton Ontario L8N 2C3 Tel: 905-528-0683 Fax: 1-866-845-2019

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)

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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. October 9, 2024