maple leaf medical clinic

Jason Brunetta, MD, CCFP · Family Practice
14 College Street · Suite 501 · Toronto, ON · M5G1K2
T 416.465.0756 F 416.465.8344 · www.mlmedical.com

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

I, _____, authorize **Dr. Jason Brunetta**
(Print your name)

to disclose

□ **my personal health information consisting of:**

_____

_____
(Describe the personal health information to be disclosed)

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

consisting of: _____

_____
(Describe the personal health information to be disclosed)

to _____
(Print your name and the address where information is to be sent)
(or if in-person pick up is preferred check this box, □ ID is required)

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 but then information cannot be released.
(Print names legibly or the form cannot be accepted.)

My Name:_____ **Address:**_____

Home Tel.:_____ Work Tel.:_____

Signature:_____ **Date:**_____

Witness 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.**

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Consent to Disclose Personal Health Information

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

I, Jack Lantern, authorize **Dr. Jason Brunetta**

(Print your name)

to disclose

☒ **my personal health information consisting of:**

entire medical chart

(Describe the personal health information to be disclosed)

or ☐ **the personal health information of** _____

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

consisting of: _____

(Describe the personal health information to be disclosed)

to Jack Lantern, 100 October Street, Toronto ON M9T 3OC

(or if in-person pick up is preferred check this box, ☐ ***ID is required)***

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 but then information cannot be released.
(Print names legibly or the form cannot be accepted.)

My Name: Jack Lantern
Address: 100 OCTOBER STREET TORONTO ON M9T 3OC
Home Tel.: 416 555 3131
Work Tel.: N/A
Signature: J Lantern
Date: OCT 31, 2022

Witness Name: Hal Evening
Address: 100 OCTOBER STREET TORONTO ON M9T 3OC
Home Tel.: 647 555 3131
Work Tel.: N/A
Signature: H Evening
Date: OCT 31, 2022

***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.**