HealthLink
Hamilton Central Health Link
Let's Make Healthy Change Happen

Consent to Disclose Personal Health Information
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 consisting of: Name, services accessed, frequency of ED and hospital visits, and any additional information disclosed by the above named.

or

☐ the personal health information of _____
(Name of person for whom you are the substitute decision-maker)*
consisting of: Name, services accessed, frequency of ED and hospital visits, and any additional information disclosed by the above named.

to the Health Links Lead team at the McMaster Department of Family Medicine

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.

Name:
_____

Address
_____
_____

Home telephone:
_____

Work telephone:
_____

Signature:
_____

Date:
_____

Witness Name:
_____

Address:
_____
_____

Home telephone:
_____

Work telephone
_____

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.**