



Inner City Health Associates

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Consent to Disclose Personal Health Information

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

I, _____, _____, _____
Print name Health Card # (if applicable) DOB: mm/dd/yyyy

Authorize: **Inner City Health Associates (ICHA)**

To share my personal health information

OR/

To share the personal health information of _____
Name of person for whom you are the substitute decision maker

with

_____, _____, _____
Name of organization/custodian/agency requesting records Address Confidential Fax Number

Please send the following records:

All records (maximum of 50 pages)
Psychiatric Assessments
Last clinical note

Discharge Summaries
Medications lists
Lab/Imaging Results

Other:

I understand the purpose for disclosing this personal health information to the organization noted above. I understand that I can refuse to sign this consent form.

My Name:

Signature:

Date:

Witness Name:

Signature:

Date: