ICHA | 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:

_____
Name of physician(s) or organization(s) with the records being requested

_____
Name of physician(s) or organization(s) with the records being requested

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 **Inner City Health Associates (ICHA)**

Please send the following records:

- ☐ **All records (maximum of 50 pages)**
- ☐ **Psychiatric Assessments/Notes, Rx, Discharge Summaries, Labs**
- ☐ **Last clinical note**

Other (Specify):

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: