Consent to Disclose Personal Health Information

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

I,

PATIENT'S NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

PHONE NUMBER: _____

HEALTHCARD NUMBER: _____

- give consent to have my medical records from (check parties that apply):

☐ **Toronto Concussion Clinic**
Phone: (647) 245-3070
Fax: (647) 670-0770

☐ **Doctor/Organization's name:**

Phone number:

Fax number:

- sent to/discussed with (check parties that apply):

☐ **Toronto Concussion Clinic**
Phone: (647) 245-3070
Fax: (647) 670-0770

☐ **Doctor/Organization's name:**

Phone number:

Fax number:

PATIENT'S SIGNATURE: _____ DATE: _____

WITNESS'S NAME: _____ DATE: _____

WITNESS'S SIGNATURE: _____ DATE: _____