

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:
