# CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

Organization: Kinex Occupational Therapy

## PART 1: CONSENT FROM INDIVIDUAL

_____ Date of Birth: _____

LAST NAME FIRST NAME DD – MMM - YYYY

Address: _____

STREE NAME AND NUMBER CITY PROVINCE POSTAL CODE

Phone Numbers: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

## DETAILS OF CONSENT

Consent to _____ disclosing the following personal health information,

NAME OF COMPANY

specifically: _____

To be disclosed to: _____

For the purpose(s) of: _____

_____

This is a consent to disclose my own information: Yes: No: **If NO – complete Part 2.**

## PART 2: PERSON PERMITTED TO EXERCISE THE RIGHTS OF AN INDIVIDUAL

_____

LAST NAME FIRST NAME

Address: _____

STREET NAME AND NUMBER CITY PROVINCE POSTAL CODE

Phone Numbers: Home: ( ) _____ Work: ( ) _____ Cell: ( ) _____

Indicate Your Authority:

**SEE CONSENT TO USE OR DISCLOSE PERSONAL HEALTH INFORMATION POLICY**

## PART 3: SIGN OFF

***I understand that this consent may be withdrawn or amended at any time. A withdrawal does not have a retroactive effect. The third party shall not use the personal health information disclosed except for the purpose specified on this consent.***

**This consent:** is valid for one year

is valid for this request only

expires on _____

DD-MMM-YYYY

Signature of Person Consenting: _____ Date: _____

DD-MMM-YYYY

*ORIGINAL TO INDIVIDUAL'S HEALTH RECORD*