CONSENT TO USE
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 using the following personal health information,

NAME OF COMPANY

specifically:

For the purpose(s) of:

This is a consent to use 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 OF DISCLOSE PERSONAK 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I understand that this consent may be withdrawn or amended at any time.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 personal health information shall not be used 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