CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

Pursuant to the Personal Health Information Protection Act, 2004

I, ______________________________________ , hereby request and authorise
(print name)

Name:____

Address:____

Phone/Fax: ____

to release and exchange psychological, educational, medical and other information (specify):

____

____

____

To:
(name of person or organization requiring/requesting the information)

Name: Dr. Gina Madrigrano of Centrepointe Professional Services_______________
Address: 98, Centrepointe Drive, Ottawa, ON, K2G 6B1, T: 613.228.1174; F:613.228.2756

From the health records of:

Name of Client: ____

Date of Birth: ____

Address: ____

This consent is effective until ____

I understand the purpose for disclosing this personal health information to the person or organization noted above. I understand that I may refuse to sign this consent form.

Signature: _______________________________________ Date: __________________
(client or substitute decision maker)

Relationship: _____________________________________

Witness: ____
(relationship to the client)