# CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

**Pursuant to the Personal Health Information Protection Act, 2004**

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

Dr. Gina Madrigrano of
Centrepointe Professional Services
98, Centrepointe Drive
Ottawa, ON, K2G 6B1
613.228.1174

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

_____

_____

_____

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

Name:_____

Address:_____

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)*