



**Consent to Disclose Personal Health Information
Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)**

I, _____, authorize of _____
(Print your name) Sogge & Associates Practice in Psychology,
9 Lewis Street, Ottawa, Ontario K2P 0S2
Fax: 613-691-0589

to disclose

my personal health information consisting of:

(Describe the personal health information to be disclosed)

or

the personal health information of _____
(Name of person for whom you are the substitute decision-maker)*

consisting of: _____

to _____
(Print name and address of person requiring the information)

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

Signature: _____ **Date:** _____

My Name: _____ **Address:** _____

Home Tel.: _____ **Work Tel.:** _____

Signature: _____ **Date:** _____

Witness Name: _____ **Address:** _____

Home Tel.: _____ **Work Tel.:** _____

***Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**