TRUE EXPERIENCE
ENGAGING. EMBRACING. EMPOWERING.

**CONSENT TO DISCLOSE INFORMATION**

I, _____, authorize

_____
*(print your name) (print name of health information custodian)*

**To Disclose**

☐ My personal health information consisting of: (Diagnosis, Medical Conditions, Physical and Mental health history relevant information we should be made aware 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: (Diagnosis, Medical Conditions, Physical and Mental health history and any relevant information we should be made aware of.)

DESCRIBE THE PERSONAL HEALTH INFORMATION TO BE DISCLOSED:

**To:** Program Staff, True Experience Supportive Housing and Community Work Program, 201 Forest St. East, Dunnville, On N1A 3G5 TEL: (905)774-6165 FAX: (905)774-4620

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.

My Name: _____ ADDRESS: _____
Home Phone: _____ Work Phone: _____
Signature: _____ Date: _____
Witness Name: _____ Address: _____
Home Phone: _____ Work Phone: _____
Signature: _____ Date: _____

*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.