IntAc
Intensive Case Management Access Coordination
20 Hughson Street South Suite 405 Hamilton Ontario L8N 2A1 Tel: 905-528-0683 Fax: 905-546-0055

Consent to Disclose Personal Health Information

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

I, _____ **Date of Birth** _____
(Print your name) *(dd/mm/yyyy)*

authorize _____
(Print name of health information custodian)

to disclose

☐ **my personal health information consisting of:**

Past and current Discharge Summaries including confirmation of psychiatric diagnosis and any of the following that maybe applicable: criminal activity, violence, incarceration, probation/parole, suicidal/homicidal ideation/attempts, social work history, vocational assessment, neuropsychological testing results.

_____

_____
(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: _____

_____
(Describe the personal health information to be disclosed)

to IntAc – Intensive Case Management Access Coordination
(Canadian Mental Health Association – Hamilton Branch, Community Mental Health Promotion Program – City of Hamilton, Hamilton Program for Schizophrenia, and Hamilton Mental Health Outreach)

_____

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

I understand the purpose for disclosing this personal health information to the agencies noted above is to determine my eligibility for case management services. I understand that I can refuse to sign this consent form.

My Name: _____ Address: _____

Home tel: _____ Work Tel: _____

Signature: _____ Date: _____

Witness Name: _____ Address: _____

Relationship to Applicant: _____ Contact Tel: _____

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.**

Form(2)03-2006-4