CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION PURSUANT TO THE PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004

I, ___________________________ (your name) , authorize Kasi Shan Therapy 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:

____

____

(Describe the personal health information to be disclosed)

to be shared with:

____ (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.

My Name:_________________________ Address:_____________________________________

Home Tel.:_________________________ Work 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. The Health Care Consent Act provides that anyone “capable with respect to treatment” may give consent to treatment on his or her own behalf. There is no discussion of a minimum age. Rather, the Act states that the health practitioner should assume that the person is capable of consenting on his or her own behalf unless there are reasonable grounds to believe otherwise.