Consent to Disclose, Transmittal, Access To or Examine Personal Heath Information

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

I____of,__
____

authorize Monique Gouthro, RP to disclose personal health information belonging to ____
Date of Birth ____

Concerning treatment from ___________________ to _______________________

Personal information to be disclosed includes:______________________________
____
____

This information may be disclosed to the following:____

I understand this personal health information is to be used ONLY by the recipient for the purpose of:
____
____
Further release of these documents is subject to client's discretion and Monique Gouthro, RP will not be responsible here forth. I hereby waive any and all claims against Monique Gouthro, RP in connection with the disclosure of this personal health information.

My name:_______________________________

Signature:______________________________

Date: __________________________________

Witness Name:_________________________

Witness Signature:_______________________________

Date:______________________________