CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

Pursuant to the Personal Health Information Protection Act, 2004

I, ____ , hereby request and authorise
(print name)

Dr. Gina Madrigrano of
Centrepointe Professional Services
98, Centrepointe Drive
Ottawa, ON, K2G 6B1
613.228.1174

to release and exchange psychological, educational, medical and other information (specify):

____

____

____

To:
(name of person or organization requiring/requesting the information)

Name:____

Address:____

From the health records of:

Name of Client: ____

Date of Birth: ____

Address: ____

This consent is effective until ____

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

Signature: _____________________________________ Date: __________________
(client or substitute decision maker)

Relationship: ___________________________________

Witness: ______________________________________
(relationship to the client)