Consent to Disclose Personal Health Information

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

I,

PATIENT'S NAME: ______________________________

DATE OF BIRTH: ______________________________

ADDRESS: ______________________________

PHONE NUMBER: ______________________________

HEALTHCARD NUMBER: ______________________________

- **give consent to have my medical records from** (check parties that apply)**:**

☐ **Institute for Behavioural & Functional Medicine**
Phone: 416-306-2001
Fax: 647-660-9355
Email: team@ibfmed.ca
Website : https://ibfmed.ca

☐ **Doctor/Organization's name:**

Phone number:

Fax number:

- **sent to/discussed with** (check parties that apply)**:**

☐ **Institute for Behavioural & Functional Medicine**
Phone: 416-306-2001
Fax: 647-660-9355
Email: team@ibfmed.ca
Website : https://ibfmed.ca

☐ **Doctor/Organization's name:**

Phone number:

Fax number:

PATIENT'S SIGNATURE: ______________________ DATE: __________

WITNESS'S NAME: ______________________ DATE: __________

WITNESS'S SIGNATURE: ______________________ DATE: __________