Consent to Disclose Personal Health Information
Pursuant to the *Personal Health Information Protection Act, 2004 (PHIPA)* and *The* Personal Information Protection and Electronic Documents Act, 2000 *(PIPEDA)* **

I, _____, **authorize** Special Needs Computer Solutions
(Print your name) *(Health information custodian)*

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 □ CNIB | □ ADP | □ Medical Professionals | □ Insurance | □ Manufacturer

_____
(Print name and address of person(s) 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: _____

Witness Name: _____Address: _____

Home Tel.: _____Work Tel.:_____

Signature: _____Date: _____

***Please note: A substitute decision-maker is a person authorized under PHIPA/PIPEDA to consent, on behalf of an individual, to disclose personal health information about the individual.**

****We maintain technological, organizational and physical safeguards in an effort to protect the personal information held by us from unauthorized use, access, disclosure, distribution, loss or alteration. Access to personal information will be restricted to our authorized personnel who require the information in order to perform their duties properly. In addition, access will be limited to only that information that is strictly necessary for the performance of those duties. The same limitations are imposed upon our third-party service providers.**

Fax: 1-877-727-9996