



Consent to disclose personal health information Form

I, \_\_\_\_\_, hereby authorize

\_\_\_\_\_  
*(Name and address of person/agency providing information)*

To share the following Personal Health Information for Consultation Purposes:

- Verbal: Related to the provision of service from Wendat Case Management Program  
 Written: Related to the provision of service from Wendat Case Management Program

\_\_\_\_\_  
*(Describe personal health information to be disclosed)*

With: \_\_\_\_\_  
\_\_\_\_\_

From the records of: \_\_\_\_\_

Name

Date of Birth

I understand that this Personal Health Information is to be used only by the recipient for the purpose of ensuring the best possible outcomes related to client care in their respective environment.

I also understand that there will be no written information taken away by other care providers.

I understand that I can refuse to sign this consent form or withdraw my consent:

Witness: \_\_\_\_\_ Signed by: \_\_\_\_\_  
(client or substitute decision maker)

Date: \_\_\_\_\_  
(relationship to client)