OTTAWA FERTILITY CENTRE
CENTRE DE FERTILITÉ D'OTTAWA

Place patient label here

# Consent to the Disclosure of Individually Identifying Health Information

*(Authorized by Section 34 of the Health Information Act)*

I, ________________________________ authorize the following self-identifying information:
(*Name of Patient)*

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

**To be disclosed by**: ______________________________________________
*(Name of Custodian)*

**In accordance with Section 34 of the Health Information Act, to**:

- ☐ Dr Paul Claman
- ☐ Dr Jeff Haebe
- ☐ Dr Delani Kotarba
- ☐ Dr Tannys Vause
- ☐ Dr Bryden Magee
- ☐ Dr Aaron Jackson
- ☐ Dr. Doron Shmorgun

**For the following purpose**: ______________________________________________

I understand why I have been asked to disclose my individually identifying information, and I am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure of my individually identifying information. I understand that I may revoke this consent at any time.

Dated this __________ of ______________, __________
Day Month Year

________________________________
Patient or Authorized Representative's Signature

________________________________
Source of Representative's Authority
(Refer to Section 104 (1) of the Act)

________________________________
Patient or Authorized Representative's Name

________________________________
Witness Signature