Patient Label

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)*

____

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____

____

To be disclosed by: ____
(Name of Custodian)

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

☐ Dr. Jenna Gale ☐ 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

____
OFC Representative Signature

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