



Empty box for 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)

Four horizontal lines for patient information

To be disclosed by: _____
(Name of Custodian)

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

- Dr. Jenna Gale, Dr. Clara Wu, Dr. Delani Kotarba, Dr. Tannys Vause, Dr. Bryden Magee, Dr. Aaron Jackson, Dr. Doron Shmorgun, Dr. Justin White

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