



Brittany Vincze Psychotherapy Services

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Consent to Disclose Personal Health Information Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I,

authorize, Brittany Vincze Psychotherapy Services

to obtain and release (*Select only one*)

My personal health information

Describe the personal health information to be disclosed:

to (print name and address of person that the information is to be shared with)

OR (only to be filled out by substitute decision makers) (*Select only one*)

The personal health information for someone whom I am the substitute decision maker

Name of person for whom you are the substitute decision-maker

Describe the personal health information to be disclosed:

to (print name and address of person that the information is to be shared with)

*Please note: A substitute decision-maker is a person authorized under PHIPA to consent on behalf of an individual to

Please note: A substitute decisionmaker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.

Informed Consent (*Select only one*)

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.

This consent will expire on this date (*YYYY-MM-DD*)

Signee Name

Signee Agreement and E-Signature

Signee Phone Number and Address

Witness Name

Witness Signature

Witness Phone Number and Address