# *AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION TO REFERRING DR.*

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

I, [print your name]

_____

authorize [print name of health information custodian]

*Dr. William Winogron, Psychologist*

to disclose

☑ my personal health information consisting of [describe the personal health information to be disclosed]:

_____

_____

or

☐ the personal health information of [name of person for whom you are the substitute decision-maker*]:

_____

consisting of [describe the personal health information to be disclosed]:

*The psychologist's summary of: impressions, diagnosis, test results and interpretations,*

*outcomes, treatment summary, prognosis, further treatment recommendations*

to [print name and address of person requiring the information]:

Dr. William Winogron, Psychologist
Dr. C. Gow & Associates, 265 Carling Ave., Suite 200, Ottawa, ON, K1S 2E1
Ph.: 613-565-0087; Fax: 613-565-5621

_____

[name of the Doctor who referred you for psychological services]

I understand the purpose for disclosing this personal health information to the person or organization noted above. I understand that I can refuse to sign this consent form or later withdraw my consent.

My Name: _____

Address: _____

Home Tel.:_____ Work Tel.: _____

Signature: _____ Date: _____

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

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