The Access Point

The Toronto Mental Health and Addictions Access Point

Consent to Disclosure

and Collection of Personal Health Information

I_____

Name of client or Substitute Decision Maker (SDM) –PLEASE PRINT

Of _____

Address

Authorize the disclosure and collection of personal health information between:

_____**and**

Name of person/agency disclosing information

_____

Name of person/agency requesting information

With regards to:

_____ _____

Name of client Date of birth

_____

Address

All information obtained will be kept confidential between the parties specified above.

I understand that I may withdraw this authorization by providing written notice at any time.

_____ _____

Name of client/SDM- PLEASE PRINT Name of witness – PLEASE PRINT

_____ _____

Signature of client/SDM Signature of witness

_____

Date