www.theclinicnetwork.ca
Phone #: 1-844-826-2665
Fax #: 1-844-262-0947
patientcare@theclinicnetwork.ca

PATIENT CONSENT FOR THE CLINIC NETWORK (TCN) TO DISCLOSE PERSONAL HEALTH INFORMATION TO A THIRD PARTY

This form MUST be completed and faxed or emailed to The Clinic Network (TCN) in order for TCN staff to disclose any personal health information to a third party.

SECTION A:

PATIENT'S FIRST NAME: _____ PATIENT'S LAST NAME: _____

DATE OF BIRTH (DD-MM-YYYY):_____ PROVINCIAL HEALTH NUMBER:_____

SECTION B:

Please provide details about the Personal Health Information (PHI) that you are authorizing be disclosed:

[checkmark below as applicable]

☐ Copy of the Medical Document (Cannabis "Prescription") ☐ Intake Questionnaires

☐ Chart Notes ☐ Follow-up Questionnaires

☐ Veterans Affairs correspondence ☐ Other _____

SECTION C:

Name of Organization/Clinic/Healthcare Provider that the Personal Health Information is being disclosed to:

_____

Address:_____ City:_____ Country_____ Postal Code:_____

Phone Number: _____ Email address: _____

Fax Number:_____

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SECTION D:

For Substitute Decision Makers:

If you are a substitute decision maker, acting on behalf of the individual whose personal health information will be disclosed, then please check the applicable boxes below. **Note: You must attach witnessed documentation, which supports any statements check marked below and verifies that you are authorized to act on the individual's behalf, in the province or territory where the patient resides, under applicable legislation:**

- ☐ I have a written, dated, signed and witnessed authorization from: _____ , authorizing me to make health care related decisions on behalf of this patient.
  FIRST AND LAST NAME OF PATIENT
- ☐ I am the individual's appointed proxy or committee and have the power to make health care related decisions for the individual.
- ☐ I am the individual's substitute decision maker for personal care.
- ☐ I am the parent or guardian of a minor and the minor does not have the capacity to make health care decisions.
- ☐ I am the patient's named attorney in a Power of Attorney – specify type: _____
  e.g. Personal Care Power of Attorney
- ☐ I am the personal representative, agent, guardian or trustee appointed for the patient.
- ☐ I am the patient's authorized specific decision maker, supportive decision maker, or co-decision maker.
- ☐ I am recognized as the patient's nearest relative and am carrying out my obligations as the nearest relative.
- ☐ Other: _____

SECTION E:

Consent Limitation*

This consent:

- ☐ is valid for this request only;
- ☐ is valid for one year;
- ☐ expires on: _____/_____/_____ [day/month/year]

***please note, if a selection is not made, by default the limitation will be 1 year.**

PATIENT'S NAME: _____

PATIENT'S SIGNATURE: _____ DATE: _____

NAME OF AUTHORIZED PERSON: _____

AUTHORIZED PERSON'S SIGNATURE: _____ DATE: _____