

Consent to Disclose Personal Health Information

To be completed by the Applicant

Version 2.3 September 2017

Pursuant to Health Information Protection Act, 2005 (HIPA)

I, _____ authorize _____ to disclose:
Your Name Name of Health Information Custodian

PLEASE SELECT:

My personal health information consisting of: Dose information of cannabis used for medical purposes, as a verification of the health care practitioner's order is required by Peace Naturals Project Inc.

The personal health information of _____ consisting of:
Name of Person for Whom You are the Substitute Decision Maker

- Dose information of cannabis used for medical purposes, as a verification of the health care practitioner's order is required by Peace Naturals Project Inc.

**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.**

MY INFORMATION		
Given Name	Middle Name(s)	Surname
Address		P.O. Box
City	Province	Postal Code
Home Telephone	Work Telephone	

My Signature	Date
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WITNESS INFORMATION		
Given Name	Middle Name(s)	Surname
Address		P.O. Box
City	Province	Postal Code
Home Telephone	Work Telephone	

Witness Signature	Date
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**Please Note: A substitute decision-maker is a person authorized under HIPA to consent, on behalf of an individual, to disclose personal health information about the individual*

To be given to your health care practitioner & a copy to Peace Naturals Project Inc.