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**854 Upper Canada Dr.,**

**Sarnia, Ontario N7W 1A4**

**www.rasci.ca**



**Consent to Disclose Personal Health Information**

**Pursuant to the Ontario Personal Health Information Protection Act, 2004 (PHIPA)**



**Patient Name:**

**Address:**

**City:**

**DOB:**

**OHIP:**

I, [Patient Name] request access to and disclosure of my personal health information and hereby authorize the release of my personal health information to Records Access Services Canada,Inc. (“RASCI”) for the purposes of personal record keeping and/or to assist in my care. I request that copies of all health information on file in connection with my treatment or health assessment be delivered in a timely manner, pursuant to Section 54(2) of PHIPA.

I have voluntarily enrolled to receive the services offered by RASCI and I consent to communication with RASCI regarding matters related to this request for my personal health information. I consent to the use of email communication with RASCI to fulfill this request and prefer the use of email wherever possible.

I have been informed of and understand the purpose for disclosing this personal health information to RASCI and have read RASCI’s privacy policy, available at https://rasci.ca/privacypolicy

I understand that I can refuse to sign this consent form and that consent can be withdrawn in writing at any time.



**I CONSENT TO DISCLOSURE OF MY PERSONAL HEALTH INFORMATION TO:**

**Records Access Services Canada, Inc.**

**c/o: Dr. Allen Greenspoon; Chief Medical Director; CPSO #: 29969**

**854 Upper Canada Dr.,**

**Sarnia, Ontario N7W 1A4**

**T: (800) 971-8038 F: (800) 928-2503**

**info@rasci.ca**

**www.rasci.ca**



**Signature of Requestor or Substitute decision maker,**

I am the requester and I am 14 years of age or older



I am the requester's parent with custody, or a person lawfully entitled to consent on behalf of the requester who is under 14 years of age



I am the requester's guardian of the person or property, or exercising a power of attorney for the requester who is an incapable adult



The requester is deceased and I am an estate trustee or have assumed responsibility for the administration of the deceased's estate and I have provided a copy of the required documentation



Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: [Date]

Name: [Patient Name]

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: [Date]

Witness Name: [Witness Name]