Consent to Release Personal Health Information

WITHDRAWAL MANAGEMENT SERVICES	
Phone	
Fax	
Name of client	
Date of birth	
Health card number	

My initials beside the names of those individuals and/or agencies is my consent for the Withdrawal Management Service to release and/or receive my personal health information (PHI):

Initials	Provider/agency type	Name
	Hospital	
	Family practitioner	
	Psychiatrist	
	Pharmacy	
	Addictions provider	
	Other:	
	Other:	

☐ Please see attached documents.

☐ Please assist in providing the following personal health information:

- ☐ Current dose of methadone, buprenorphine, or slow-release oral morphine
- ☐ Length of time on current dose of methadone, buprenorphine, or slow-release oral morphine
- ☐ Date of last dose increase
- ☐ Last witnessed dose of methadone, buprenorphine, or slow-release oral morphine
- ☐ Name of pharmacy where dose was received
- ☐ Carry status
- ☐ Last 2 urine and/or broad spectrum chromatography results
- ☐ Other: _____

_____

I understand the purpose for sharing this personal health information with the above noted person(s).

I understand that I can decline to sign this consent form.

I understand that I can withdraw my consent at any time by providing written or verbal notice. Consent is otherwise valid until the file is closed.

Signature of client	**Date**
Signature of parent/guardian/caregiver/ substitute decision maker (where applicable)*	**Date**
Signature of witness	**Date**

A copy of the Consent to Obtain or Release Information is available upon request to the person signing this form.

This form is in accordance with s.38(2) of the Freedom of Information and Protection of Privacy Act.R.S.O. 1990 c. F.31 as amended.

*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.