Consent to Disclose Personal Health Information

To be completed by the Applicant

Version 2.0 May 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 marijuana 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 Your are the Substitute Decision Maker**

- Dose information of marijuana 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**

WITNESS INFORMATION

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

Witness Signature	**Date**

****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.

"Peace is its own reward." - Gandhi

The Peace Naturals Project

Mail: P.O. Box 999 Stayner, ON L0M 1S0 **Fax:** 1.855.888.9973 **Email:** clientcare@peacenaturals.com

Toll Free: 1.888.64.PEACE (73223) | www.peacenaturals.com