# Consent to Disclose Personal Health Information

To be completed by the Applicant

Version 2.1 June 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:** physicians@peacenaturals.com

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