Consent to Disclose Personal Health Information

IMPORTANT NOTE: Please ensure that we receive a copy of this document as it is required to verify your prescription.
Peace Naturals Referral Program

Pursuant to Health Information Protection Act, 2005 (HIPA) Version 2.0 January 2017

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

Title	Given Name	Surname
Address		
City	Province	Postal Code
Home Telephone	Work Telephone	
My Signature		**Date**

Witness Information

Title	Given Name	Surname
Address		
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 or courier completed form to:
P.O. Box 999 | Stayner, ON | L0M 1S0

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