Jennifer Brighton, M.S.W., R.S.W., CCP

Counselling, Psychotherapy & Coaching

Consent to Disclose, Transmittal, Access To or Examine Personal Heath Information

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

I ____, of
____
____

authorize **Jennifer Brighton, M.S.W, R.S.W., CCP** to disclose personal health information belonging to

____

Date of Birth ____

Concerning treatment from ____________________ to _____________________

Personal information to be disclosed includes:___________________________
____
____

This information may be disclosed to the following:__________________________
____

I understand this personal health information is to be used ONLY by the recipient for the purpose of: ____
____

Further release of these documents is subject to client's discretion and Jennifer Greve, M.S.W., R.S.W. will not be responsible here forth.

I hereby waive any and all claims against Jennifer Brighton, M.S.W., R.S.W., CCP in connection with the disclosure of this personal health information

____________________________	____________________________
My Name	Signature
____________________________	____________________________
Date	Address
____________________________	
Contact Telephone Number	
____________________________	____________________________
Witness Name	Witness Signature
____________________________	____________________________
Witness Relationship	Date