Tribunals Ontario

Criminal Injuries Compensation Board

655 Bay Street, 14th Floor
Toronto, ON M7A 2A3
Toll Free: 1-800-372-7463
Tel: (416) 326-2900 | Fax: (416) 326-2883
www.sjto.ca/cicb

Consent to Disclose Personal Health Information

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

Victim Information

File Number		
Last Name	**First Name**	**Middle Name**

Last Name at Birth	**Any Other Name(s)**
Gender	**Date of Birth:**

(hereinafter referred to as the "Victim"

I ,THE UNDERSIGNED, authorize _____ to disclose

(Name of Health Information Custodian)

☐ my personal health information

or

☐ the personal health information of the Victim (*if you are the substitute decision maker for the Victim)

consisting of**:** (information requested in the attached report)

_____

(Describe the Nature of Injuries and/or Treatment, Reason(s) Given for Visit(s) or the personal health information to be disclosed)

_____

(Date of Visit or Period of Visits (YYYY/MM/DD)

to: **Criminal Injuries Compensation Board**
(655 Bay Street, 14th Floor, Toronto, Ontario M7A 2A3)

I understand the purpose for disclosing this personal health information to the organization noted above. I understand that I can refuse to sign this consent form. By signing below, I also authorize the Criminal Injuries Compensation Board to communicate with the health care provider named above and to disclose my personal information (or the Victim's personal information) and any other information about my application (or the Victim's application) to the said health care provider to assist them in locating the personal health information referenced above.

My Name:		**Address:**	
Home Telephone:		**Work Telephone:**	
Signature:	**X**	**Date:**	

Witness Name:		**Address:**	
Home Telephone:		**Work Telephone:**	
Signature:	**X**	**Date:**	

***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.**