SPECS AND SPINES
OPTOMETRY & CHIROPRACTIC

2398 Lake Shore Boulevard, Unit #6 Toronto ON M8V 1C3
TEL: 416-251-4448-/ FAX: 416-251-4887
info@specsandspines.com

Consent for Release/Request of Personal Health Information

Pursuant to the Personal Health Information Protection & Electronic Documents Act, 2004 (PHIPEDA)

PATIENT IDENTIFICATION:

Name: _____ DOB: _____
Patient Name *DD/MONTH/YYYY*

Guardian or Parent Name (if patient <18 yrs): _____

I, _____, hereby authorize Specs & Spines Optometry to
patient name

☐ release / ☐ request (*check one*) personal health information ☐ to / ☐ from (*check one*):

Name of Doctor/Clinic: _____

Mailing Address: _____ City/Province: _____

Postal Code: _____ Tel / Fax: _____

INFORMATION DESCRIPTION

Information being requested or released:

☐ Spectacle prescription
☐ Ocular health history
☐ Referrals/Reports from specialists
☐ Contact Lens prescription
☐ Visual Fields, Retinal Photos, Ancillary testing

☐ Requesting transfer of complete patient file and ocular history

Limited Access or Restriction Instructions:(specify): _____

PERMISSION

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.

Name: _____

Date: _____ Signature: _____
DD/MONTH/YYYY *Original Signature of patient or Parent/Guardian*

A substitute decision-maker is a person authorized under PHIPEDA to consent, on behalf of an individual, to disclose personal health information about the individual.

For Office Use Only:

Processed by: _____
Date: _____ DD/MONTH/YYYY