Registered Massage Therapists' Association of Ontario

Consent to Disclose Personal Health Information

(This consent will be reviewed every six months)

I, _____ hereby authorize _____

Patient/Substitute Decision Maker Name Registered *Massage Therapist*

to disclose the following personal health information:

(Description of personal health information to be disclosed and dates of contact)

to

(Name and address of person/agency requesting information)

from the records of _____ _____

Patient Name *Date of Birth*

Patient Mailing Address:

I understand that this personal health information is to be used **only** by the recipient for the purposes of:

Date:

I hereby waive my right to bring any action or make any complaint or claim against _____, Registered Massage Therapist, in connection with the disclosure of this personal health information.

Witness: Signed: _____

Patient/Substitute Decision Maker

Date:

Relationship to Patient