MUSHKEGOWUK COUNCIL ᐅᒪᐡᑯᑯ ᐅᑭᒪᐃᐧᐃᐧᐣ

MUSHKEGOWUK HEALTH PRIMARY CARE
CONSENT FORM – PHARMACY RECORDS

MUSHKEGOWUK HEALTH
Okimawiwin Minopimatisiwinik Atoskawikamik

Consent to Obtain Health and Medication Records from Pharmacy

I, ____, **hereby authorize:**

(Please print name of patient/substitute decision maker above)

Name of Pharmacy:		
Address:		
Phone #:		Fax #:

To disclose any personal health information as well as current and past medication information.

Disclose to Following Recipient:

Mushkegowuk Health Primary Care at 11 Elm St. North, Timmins, ON P4N 6A3
Phone: 705.269.6662, Toll Free: 1-855-687-4492, Fax: 1-888-777-5708

Patient Name: ______________________________ DOB: ______________________

Address: ____

City: ______________________ Postal Code: __________ Phone: _______________

I understand that this personal health information is to be used ONLY by the recipient for the purposes of providing primary care. I hereby waive all claims against Mushkegowuk Health and the Primary Care provider, in connection with my now authorized disclosure of this personal health information.

Signed by Patient: ____

Signed by Substitute Decision Maker: ____

Date: ____