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

I, _____, **authorize**_____
(Print your name) *(Print name of health information custodian)*

to disclose

☐ my personal health information consisting of:

Report of physical including health history information, limitations and certification of active participation in such activities as camping and youth work._____

(Describe the personal health information to be disclosed)

or

☐ the personal health information of _____
(Name of person for whom you are the substitute decision-maker)*

consisting of:_Report of physical including health history information, limitations and certification of active participation in such activities as camping and youth work._____

(Describe the personal health information to be disclosed)

to SDB SCSC Committee, PO Box 1678, Janesville, WI 53547-1678 USA
(Print name and address of person requiring the information)

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.

My Name:_____ **Address:**_____

Home Tel.:_____**Work Tel.:**_____

Signature:_____**Date:**_____

Witness Name:_____**Address:**_____

Home Tel.:_____**Work Tel.:**_____

Signature:_____**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.**