



**CAN-AM
CRYO SERVICES
CORP**

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**CONSENT TO THE DISCLOSURE, TRANSMITTAL OR EXAMINATION
OF PERSONAL HEALTH INFORMATION**

I, _____ have reviewed the Personal Information
(Full Legal Name of Patient or Substitute Decision-Maker)

Protection Policy concerning the collection, use and disclosure of Personal Health Information (PHI) by CAN-AM Cryoservices Corp. (CAN-AM).

I understand my express consent is being requested to disclose the following PHI, or portions thereof*: _____

(Description of PHI to be disclosed and dates of contact)

To: _____

(Name and address of person/agency requesting information)

From the medical record of: _____
(Name of Patient) _____
(Date of Birth mm/dd/yyyy)

Mailing Address of the Patient: _____

I understand that the information is to be used only for the purposes of: _____

I understand that I may withdraw this consent for disclosure by giving written notification to the Privacy Information officer of CAN-AM Cryoservices Corp. as outlined in the Privacy Policy, before the disclosure occurs.

I hereby waive any and all claims against CAN-AM Cryoservices Corp. in connection with the disclosure of this Personal Health Information.

*Signature of Patient or Substitute Decision-Maker
(and relationship to patient, if applicable)*

Witness (Name)

Dated this _____ day of _____, 20_____

Witness (Signature)

*Transmission of disclosed information includes by Facsimile, E-mail, Courier or Post.