Mount Sinai Fertility
Sinai Health System

CONSENT TO DISCLOSE
PERSONAL HEALTH INFORMATION

I authorize the Sinai Health System to disclose my Ontario health card number to the Ministry of Health and Long-Term Care of Ontario for the purpose of administering the funded fertility services program.

I authorize the Ministry of Health and Long-Term Care of Ontario to use my personal health information for the purposes of ensuring that the Sinai Health System complies with requirements of the funded fertility services program.

I understand the purpose of disclosing this personal health information to the Ministry of Health and Long-Term Care. I have been provided with an opportunity to ask questions, and have received satisfactory answers to any questions I have asked.

I understand that I can refuse to sign this Consent Form, but that this will affect my eligibility to receive funded fertility services.

Signed this _____ day of _____, _____
Day Month Year

_____ _____
Patient/Client Signature Witness Signature

_____ _____
Patient/Client Printed Name Witness Printed Name