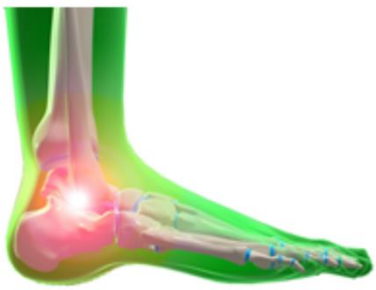

Maczko Chiropody and Orthotic Centre
559 Exmouth Street
Sarnia, Ontario N7T 5P6
519-337- 9540 voice 519-337-2566 fax
www.sorefoot.ca
info@sorefoot.ca

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION
Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

I, _____
Full Name of Patient OR Legal Guardian

of_____
Street Address City, Province Postal Code

Do hereby authorize the exchange of pertinent health information, specifically:

Chiropody Foot Health Care **For the purposes of**: Transferring personal health information to a new Chiropody Clinic

Between Maczko Chiropody & Orthotic Centre and:

Lambton Chiropody and Health Centre
Name of Person or Facility with whom the information will be exchanged

In respect to:

_____ _____
Patient's Name Patient's Date of Birth

I understand the purpose for disclosing this health information. I understand that I can refuse to sign this consent form or later withdraw my consent. Until consent is withdrawn, further disclosure is permitted to the identified person or facility above for the same purpose. This consent will remain active until the patient is discharged, or until consent is withdrawn.

_____ _____
Patient Witness

_____
Date of Consent (yyyy-mm-dd)

Revised: August 8, 2026