Ontario College of Pharmacists
Putting patients first since 1871

Ontario College of Pharmacists
483 Huron Street
Toronto, ON M5R 2R4

THIRD PARTY CONSENT FORM

I, _____, authorize _____ to act as my
(Full Patient Name) (Full Complainant Name)
representative (the "Complainant") for the complaint they filed on my behalf with the Ontario College of Pharmacists (the "College").

I authorize the College to collect any and all relevant records from my pharmacy, medical physician and/or any other health care professional that may have information directly related to this complaint.

I understand that my personal health information may be shared with the complainant and the Member(s) in the course of investigating or resolving this matter.

I understand that the investigation file, including medical records obtained, will be forwarded to the Inquiries, Complaints and Reports Committee ("ICRC") for its review and disposition of this complaint.

I acknowledge my understanding that the College and the members of the ICRC will maintain my health records in a confidential manner.

_____ _____
Patient's signature **Date**

_____ _____
Witness signature **Date**

_____
Patient Date of Birth

_____
Relationship with Complainant