



CONSENT FORM

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

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

I understand that while the College will maintain my personal information and my personal health information in a confidential manner, this information may be shared with the Complainant and the Registrant(s) identified in this complaint.

I further understand that the entire investigation file will be shared with the Health Professions Appeal and Review Board (“HPARB”) should the Complainant or the Registrant(s) identified in this complaint request HPARB to review the decision made by the Inquiries, Complaints and Reports Committee (“ICRC”) in relation to this complaint. The information shared with HPARB may include my personal information and my personal health information.

I am aware that my personal information includes, but is not limited to, my telephone number, my email address and/or my mailing address. My personal health information includes, but is not limited to, my medical records and/or my prescriptions.

Patient’s signature

Date

Date of Birth

For more information about the College’s processes in relation to the investigation of complaints, including the roles of the ICRC and HPARB, please review the College’s website at <https://www.ocpinfo.com/protecting-the-public/complaints-reports/file-a-complaint/>