DEPARTMENT OF HEALTH AND SOCIAL SERVICES

PHYSICIAN AFFIRMATION OF CAPACITY UNDER HIPMA

This form is to be completed only by a physician or nurse practitioner for the purpose of the determination of an individual's capacity under s.45 of the *Health Information Privacy and Management Act (HIPMA)*.

Individual for whom capacity to consent is being determined	
Full name	Date of birth YYYY/MM/DD
Proposed substitute decision maker information	
Full name	Residential address / Territory/Province
Physician/nurse practitioner information	
Full name	Telephone number
Profession (M.D. or nurse practitioner)	
License #	
Address	

I, _____ have examined the above-named individual and, based on my examination, affirm that the above-named individual (check only those that apply):

☐ is not able to understand the information that is relevant to deciding whether to consent to the collection, use or disclosure of their information for the purpose of:

- an access to information request;
- a request for a proof of vaccination credential.

☐ is not able to appreciate the reasonably foreseeable consequences of giving, refusing, withholding or withdrawing consent to the collection, use or disclosure of their information for the purpose of:

- an access to information request;
- a request for a proof of vaccination credential.

_____ YYYY/MM/DD _____

Signature Date

Please note that, if further information is needed with respect to this Affirmation, the Department of Health and Social Services may contact you.

Information is collected, used and disclosed in accordance with *Yukon's Health Information Privacy and Management Act* and other applicable laws. A written statement of Health and Social Services information practices can be viewed at www.yukon.ca/healthprivacy or by contacting the department's Privacy Officer at healthprivacy@yukon.ca.

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