

CONSENT FOR ACCESS OR DISCLOSURE OF PERSONAL HEALTH INFORMATION



DATE: (DD/MM/YY) _____

PIN # _____
H/C # _____

I CONSENT TO ALLOW: (for St. Joseph's office use only)

- | | |
|---|--|
| <input type="checkbox"/> St. Joseph's Hospital | <input type="checkbox"/> Parkwood Institute Main Building |
| <input type="checkbox"/> Parkwood Institute Mental Health Care Building | <input type="checkbox"/> Southwest Centre for Forensic Mental Health |
| <input type="checkbox"/> Family Medical Centre | <input type="checkbox"/> Mount Hope |

TO ACCESS/DISCLOSE THE FOLLOWING INFORMATION: (If applicable, specify dates of visits, contacts, hospitalization, treatment, or other information required)

PATIENT:

Patient Name: _____ Date of Birth: _____
Last Name Given Name Middle Name (YYYY / MM / DD)

Address: _____ Telephone #: _____

Person / Agency to receive information: _____

Address: _____ Telephone #: _____

Email: _____

Patient or person with legal signing authority consenting to access/disclosure:

Printed Name: _____ Signature: _____

Address & Telephone # if different than patient/client: _____

Office Use only - Verification of identity of individual consenting to the access/disclosure:

Form of ID: Health Card Driver's Licence Power of Attorney/Executor of Estate documentation

Passport Other (specify) _____

ID Checked by _____
Printed name Signature

PLEASE NOTE: This Consent for Access or Disclosure pertains to the disclosure of information that is specific to treatment received on or before the date signed. It can be altered or withdrawn by the patient or person with legal signing authority at any time by notification to the hospital. Withdrawal of consent is not retroactive to information already released.