CONSENT FOR ACCESS OR DISCLOSURE OF PERSONAL HEALTH INFORMATION

DATE: (DD/MM/YY) _____

PIN # _____

H/C # _____

I CONSENT TO ALLOW:

- ☐ St. Joseph's Hospital
- ☐ Parkwood Institute Main Building
- ☐ Parkwood Institute Mental Health Care Building
- ☐ Southwest Centre for Forensic Mental Health
- ☐ Family Medical Centre
- ☐ Mount Hope
- ☐ Other facility, practitioner, or agency (specify):_____

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: _____

_____

Hospital 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 It can be altered or withdrawn by the patient or person with legal signing authority at any time by notification to the hospital.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.