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* D 0 6 1 8 A *

Addressograph /
Patient ID Label (Bar Code)

CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I _____
Client/Patient Name: (Print Last Name, First Name)

hereby authorize the _____ to disclose personal health information
Name of Person/Agency Disclosing Information

to

Name of Person/Agency Requesting Information

of _____
Street Address City Province Postal Code

from the records of:

_____ _____ _____
Print Client/Patient Name Date of Birth (dd/mm/yyyy) Health Card #

_____
Street Address City Province Postal Code

I consent to the following specific information to be disclosed (please check all appropriate items):

- ☐ Mental health/addictions admission history
- ☐ Medical history
- ☐ Other (Please Specify):_____
- ☐ Medical and psychiatric consultation reports
- ☐ Discharge summary
- ☐ Medications summary

_____

Information is being released for the purpose of: _____
_____
_____

How may this information be released (choose all that apply)? ☐ Verbally ☐ Photocopy

_____ _____
Signature of Witness Signature of Client/Patient

_____ _____
Print Name of Witness (if other than client/patient, print name and state relationship)

Date: _____
(dd/mm/yyyy)

Additional Instructions: _____
_____

This authorization may be withdrawn in writing at any time.

All Consent for Disclosure of Personal Health Information forms must be delivered to the Health Records department to be processed. An administrative fee may be applied to cover photocopying and related costs.

FOR INTERNAL HEALTH RECORDS/CLINICAL STAFF USE ONLY

INFORMATION RELEASED BY: ☐ Verbal Communication ☐ Mail ☐ Fax

F0140-20060825