Consent to Disclose Personal Health Information

Pursuant to the Personal Health Information Protection Act, 2004

St. Joseph's Health Centre
30 The Queensway, Toronto, ON M6R 1B5
Tel: 416-530-6047 Fax: 416-530-6046

ST. JOSEPH'S HEALTH CENTRE TORONTO

I, _____
(Print your name)

AUTHORIZE ST. JOSEPH'S HEALTH CENTRE TO DISCLOSE PERSONAL HEALTH INFORMATION TO:

NAME: _____
(*examples: patient, family member, doctor, hospital, insurance co. etc.*)

ADDRESS: _____
(Complete Address)

TELEPHONE #: _____ **FAX #:** _____

☐ My personal health information consisting of:

_____
(Describe the personal health information to be disclosed - include treatment dates & type of reports)

OR

☐ The personal health information of:

_____
*(Name of person for whom you are the substitute decision-maker**)*

Consisting of: _____

(Describe the personal health information to be disclosed - include treatment dates & type of reports)

DATE OF BIRTH: DD/MM/YYYY **HEALTH CARD #:** _____

ADDRESS: _____
(Complete Address)

TELEPHONE #: _____

SIGNATURE: _____ **DATE** DD/MM/YYYY

WITNESS NAME: _____ **WITNESS SIGNATURE:** _____
(Print name)

*A substitute decision maker is a person authorized under the Personal Health Information Protection Act to consent, on behalf of an individual, to disclose personal health information about the individual.

For Release of Information Office use only:
Date Received: _____ **Request #:** _____ **Chart #:**_____

Comments: _____ **ID Checked:** _____

♦**Please note that Photo I.D is required to confirm identity.**

The consent form is valid for a period of three months **from the date the form is signed.**