L'HÔPITAL DU DISTRICT DE GERALDTON DISTRICT HOSPITAL GERALDTON OODENA AAKOZIIWIGAMIG

HEALTH RECORDS DEPARTMENT
L'Hôpital du district de Geraldton District Hospital
500 Hogarth Ave. West, Postal Bag 4 | 500, avenue Hogarth Ouest, C.P. 4
Geraldton, ON P0T 1M0
(T) 807.854.1862 (F) 807.854.4204 Geraldtondh.com

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I, _____, hereby authorize
(First name, last name)

GERALDTON DISTRICT HOSPITAL to disclose the following personal health information:

_____

_____
(Describe the personal health information to be disclosed – include treatment date & types of reports)

From the record of:

NAME:_____
*(Your own name if it is your record, or the name of the person for whom you are the substitute decision-maker)**

DATE OF BIRTH: _____ HEALTH CARD NUMBER: _____
(DD / MM / YYYY)

ADDRESS:_____

To the following individual or facility:

☐ Personal ☐ Lawyer ☐ Insurance ☐ Care provider ☐ Other:_____

RECIPIENT NAME: _____
(Name of person, family member, doctor, hospital, insurance, etc. who is to receive the personal health information)

ADDRESS:_____

PHONE NUMBER:_____ FAX NUMBER: _____

Print: Patient Name/Substitute Decision Maker

_____

Signature & Relationship:

_____

Date:

_____
(DD / MM / YYYY)

Print: Name of Witness

_____

Signature of Witness

_____

*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.

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.