



Enriching Care
Enhancing Knowledge
Enlightening Minds

*** CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION FORM**

I _____ hereby authorize _____
(Name of hospital/physician's office)

To disclose the following personal health information:

(Description of personal health information to be disclosed and dates of contact/hospitalization)

To _____

(Name, address and telephone number of person/agency requesting information)

from the records of _____
(Name of Patient) (Birth date)

Mailing Address of Patient: _____

I understand that this personal health information is to be used **only** by the recipient for the purposes of:

Date: _____

Witness: _____
(Not the intended recipient)

Signed by: _____
(Patient or Substitute Decision-Maker)

Date: _____

(Relationship to the Patient)

If you are the substitute decision-maker, please provide supporting documentation (e.g. Power of Attorney)

* Privacy Office Extension 3443 privacy@baycrest.org