Baycrest

*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: _____ Signed by:_____
(Not the intended recipient) **(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 6300 privacy@baycrest.org