Consent to the Disclosure of Personal Health Information

I, ____
(print full name of person or Substitute Decision-Maker)

of ____
(address)

hereby authorize ____
(print name of person / facility releasing information)

to disclose personal health information of ____
(name of patient) (date of birth)

to ____
(print name of person / facility requesting information)

of ____ .
(address)

Specify information to be released ☐ verbally ☐ copies of record of personal health information

____

____

____

____

____

I understand the purpose for disclosing the personal health information to the person / facility noted above.

I hereby waive any and all claims against the Ontario Shores Centre for Mental Health Sciences, its Board of Directors, its physicians and its employees, officers and agents in connection with the release and disclosure of the above described information.

____
(print name of witness)

____
(signature of patient / Substitute Decision-Maker)

____
(signature of witness)

____
(if other than the patient, state relationship to the patient)

____
Date (year / month / day)

I understand that I may withdraw this consent at any time by contacting a member of my treatment team or Health Information Management.

This consent will become null and void if I become incapable of consenting to the disclosure of personal health information.

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