Ontario Shores
Centre for Mental Health Sciences

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 or individual to whom you are consenting to have access to your/the patient's Patient Portal account)

of _____
(address)

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

_____

☐ Authorization to Create an Ontario Shores' HealthCheck Patient Portal Account on my/the patient's behalf.

If checked complete this section providing delegate information. A delegate is a person that has been granted permission by you to create a Ontario Shores' HealthCheck Patient Portal account and have access to your/the patient's personal health information available within the Ontario Shores' HealthCheck Patient Portal on an ongoing basis, until your consent is withdrawn.

Delegate Last Name	
Delegate First Name	
Date of Birth (DD/MM/YYYY)	
Delegate Address	
Delegate Phone Number	
Delegate email	

I understand the purpose for disclosing the personal health information to the person I facility noted above.
I understand that by checking the authorization for Ontario Shores' HealthCheck Patient Portal access, providing the delegate information and signing this form, I am giving permission to Ontario Shores to enable the delegate to create an Ontario Shores' HealthCheck Patient Portal user account and access my/the patient's personal health information, as available in the Ontario Shores' HealthCheck Patient Portal on an ongoing basis and therefore to information collected and recorded about me/the patient in the future.
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 (day / month / year)

I understand that I may withdraw this consent at any time by contacting a member of my treatment team or Health Information Management. Delegate Patient Portal accounts will be closed upon my request by contacting Health Information Management.

This consent will become null and void if I become incapable of consenting to the disclosure of personal health information, or if there is a change in Substitute Decision Maker status.