

ST. FRANCIS MEMORIAL HOSPITAL
P.O. Box 129, 7 St. Francis Memorial Drive
Barry's Bay, ON K0J 1B0

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION
Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

Directive: I, _____ hereby authorize
 St. Francis Memorial Hospital, or
 other _____, to

Disclose Transmit Permit examination of, records pertaining to the
admission/visit(s) on the following date(s): _____
(dates of visit(s)/hospitalization)

from the health records of _____
(name of patient) (Date of Birth, yyyy/mm/dd)

(mailing address of patient)

to _____
(name and address of person/agency requesting information)

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

- | | |
|--|---|
| <input type="checkbox"/> Further medical treatment | <input type="checkbox"/> Litigation |
| <input type="checkbox"/> Physician reference | <input type="checkbox"/> Estate settlement |
| <input type="checkbox"/> Insurance claim | <input type="checkbox"/> Mental Health Assessment &/Treatment |
| <input type="checkbox"/> Personal family information | <input type="checkbox"/> Other _____ |

Consent: I understand the private and confidential nature of this information and
agree that it will be used only for the stated purpose(s). I hereby waive any and all
claims against St. Francis Memorial Hospital in carrying out this directive.

Signed by _____
(Patient or Substitute Decision-Maker) (relationship to the patient)

Signature of Witness: _____ Date: _____

NOTE: This Authorization must contain the original signature of:

- the patient ;
- the parent or legal guardian if the patient is under 16 years of age and incapable;
- the legal representative/substitute decision-maker if the patient is incapable or
deceased;
- the witness to the patient's signature.