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:

☐ Further medical treatment
☐ Physician reference
☐ Insurance claim
☐ Personal family information
☐ Litigation
☐ Estate settlement
☐ Mental Health Assessment &/Treatment
☐ 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:
a) the patient ;
b) the parent or legal guardian if the patient is under 16 years of age and incapable;
c) the legal representative/substitute decision-maker if the patient is incapable or deceased;
d) the witness to the patient's signature.