SFMH
ST. FRANCIS MEMORIAL HOSPITAL

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

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Records to be Accessed: Patient:_____ Date of Birth (dd/mm/yyyy)_____ Health Card Number:_____ Phone Number:_____ Address:_____ City:_____Postal Code:_____	**Recipient of Records:** ◉ **Patient** ○ **Substitute Decision Maker** ○ **Other** **Name:**_____ Phone Number:_____ Fax Number:_____ Address:_____ City:_____Postal Code:_____

Records to be Disclosed:

Personal Health Information relating to the following treatment or admission (Specify health information and dates of service)

_____

_____

_____

_____

Reason for Request and Release of Information:

I, _____hereby authorize St. Francis Memorial Hospital to disclose the aforementioned health information to the recipient indicated for the purpose of:

☐ **Ongoing Care** ☐ **Personal** ☑ **Legal** ☐ **Insurance** ☐ **Other (specify):**_____

Signature of Patient or Substitute Decision Maker_____ **Date:**_____

Signature of Witness:_____ **Date:**_____

NOTE: A substitute decision maker (SDM) is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual. This Consent for Access to Disclosure will be valid for a three (3) month period as of the date of the signature unless otherwise specified. This authorization may be withdrawn at any time by written notification to the hospital, but is not retroactive to information released before consent is withdrawn.

Fee: $30.00 (basic search fee, non-refundable + $0.25 per page after 20