



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: <table border="0"> <tr> <td style="text-align: center;">Patient</td> <td style="text-align: center;">Substitute Decision Maker</td> <td style="text-align: center;">Other</td> </tr> <tr> <td colspan="3">Name: _____</td> </tr> <tr> <td colspan="3">Phone Number: _____</td> </tr> <tr> <td colspan="3">Fax Number: _____</td> </tr> <tr> <td colspan="3">Address: _____</td> </tr> <tr> <td colspan="3">City: _____ Postal Code: _____</td> </tr> </table> | Patient | Substitute Decision Maker | Other | Name: _____ | | | Phone Number: _____ | | | Fax Number: _____ | | | Address: _____ | | | City: _____ Postal Code: _____ | | |
| 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 This authorization may be withdrawn at any time by written notification to the hospital, but is not retroactive to information released before consent is withdrawn.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)

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