Consent for Disclosure and Requesting of Personal Health Information

Based on the Personal Health Information Protection Act, 2004

Patient/Client Name _____ Date of Birth _____
LAST NAME FIRST NAME INITIAL *(YYYY MM DD)*

Address _____

City _____ Province _____ Postal Code _____

Home/Work Telephone _____ Cell Phone _____

I, _____ hereby authorized
(Patient's Name, Substitute Decision Maker (SDM) or Legal Representative)

Humber River Hospital to: ☐ **Release to:** ☐ **Collect from:**

Name of Third Party/Health Care Institution/Health Care Provider _____

Address _____

City _____ Province _____ Postal Code _____

Telephone _____ Fax Phone _____

Personal Health Information relating to the following treatment or admission*: (specify health information & dates of services)*

_____

_____

Collecting From: Please fax requested information back to: _____
(List Contact Name, Unit or Clinic)

Phone: _____ Fax: _____

☐ Wilson Site
1235 Wilson Ave
Toronto, ON M3M 0B2
Phone: 416-242-1000 ext 82300
Fax: 416-242-1085

☐ Finch Avenue Site
2111 Finch Avenue West
Toronto, ON M3N 1N1
Unit Phone: _____
Unit Fax: _____

☐ Church Street Site
200 Church Street
Weston, ON M9N 1M8
Unit Phone: _____
Unit Fax: _____

The reason for this request is: _____

Signature of Patient, SDM or Legal Representative: _____ Date: _____

Relationship to the Patient (if not the patient): _____

Signature of Witness: _____ Date: _____

Print Name of Witness: _____

The witness signature needs to be a neutral third party, who does not benefit from signing this legal document. The witness must be of legal age and must be mentally capable in making their own decisions and has known the signer of the document for a long time. The witness must actually see the signer sign the document and verifies that the signer of this legal document is not an imposter.

Notes: **1.** This authorization is valid for a period of 90 days from the date of signing and may be rescinded or amended in writing during that period except where action has been taken based on authorization provided & shall only apply to information dated prior to date of signature.

2. The authorization must contain:

a) The signature of the patient (capable individual who is 16 years or older to whom the record pertains); or
b) The signature of a person who is authorized by the patient to receive the information on the patient's behalf;
c) The signature of the patient's legal representative if the patient is deceased or has been certified mentally incompetent.
d) The signature of the witness to the patient's or authorized representative's signature.

3. If the person does not read or understand English, the authorization form must be interpreted for the patient. The person who acts as the *interpreter must* sign the form as a *witness* to confirm that this has been done.