Hamilton Health Sciences

FOR INTERNAL OFFICE USE ONLY

PATIENT ID NO. _____

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION FORM

I _____hereby authorize _____
(Name of hospital/physician's office)

to disclose the following health information:

_____

_____
(Description of personal health information to be disclosed and dates of contact/hospitalization)

to _____

_____
(Name and address of person/agency requesting information)

from the records of _____
(Name of Patient – Please Print) **(Birth Date)**

Mailing Address of Patient: _____
_____
_____ OHCN: _____

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

_____

_____

I hereby waive any and all claims against _____
(Name of hospital/physician's office)
in connection with the disclosure of this personal health information.

Date: _____ Signature: _____
(Patient or Substitute Decision Maker)

Witness: _____ Signed by: _____
(Relationship to the Patient)

Attention: Release of Information
Health Records - Hamilton Health Sciences
McMaster Site
1200 Main Street West, Hamilton, Ontario L8N 3Z5
Telephone: 905.521.2100 x75123

This form is valid for 90 days from date of signature.

July, 2008