CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I________________________, hereby authorize _____________________________________
(Name of site or organization releasing information)

to release the following personal health information:

____

____

____
(Description of information to be disclosed including dates of hospital visits)

to____

____

____
(Name and address of person/agency)

from the records of:

____
(Name of Patient) (Birth Date) (LH Unique #)

____
(Mailing Address)

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

____

____

Date:_________________________ Expiry date:_____________________________________
(3 months from date signed unless otherwise stated)

I hereby waive any and all claims against Lakeridge Health, its Board of Governors, its physicians and its employees, officers and agents in connection with the release and disclosure of the above described information.

Signed By: _______________________________ Witness: ____________________________
(Patient or Substitute Decision Maker)

Relationship _______________________________ Date: ____________________________
to the patient (if signed by Substitute Decision Maker)

Note: This authorization may be rescinded or amended in writing at any time prior to the expiration date, except where action had been taken in reliance on the authorization.

Revised April 2014