UNIT NUMBER:______________

# Consent to Disclosure of Personal Health Information

I hereby authorize the Hospital:

- ☐ Groves Memorial Community Hospital, 131 Frederick Campbell Street, Fergus, ON, N1M 0H3 (519) 843-2010
- ☐ NWHC-Louise Marshall Hospital, 630 Dublin St., Mount Forest ON N0G 2L3 (519) 323-2210
- ☐ NWHC-Palmerston and District Hospital, 500 Whites Road, Palmerston, ON N0G 2P0 (519) 343-2030

to disclose information to the following individual/organization:

**RELEASE TO:** ______________________________________________
(Name of institution, agency or person)

______________________________________________
(Address of recipient)

Visit/Assessments Dates: ______________________________________________

______________________________________________

**Specify Information to be released:** __________**Verbal** __________**Written**

| | | |
|---|---|---|
| ☐ Emergency Record | ☐ Pathology report | ☐ Audiology Notes |
| ☐ History and Physical | ☐ Laboratory report(s) | ☐ Physiotherapy Report |
| ☐ Consultation | ☐ Radiology report(s) including ultrasound | ☐ Social Work Report |
| ☐ Discharge Summary | ☐ Radiology images including ultrasound | ☐ Psychosocial Report |
| ☐ Operative Report | ☐ ECG (s) | |
| Other (Specify) | | |

**Purpose of the disclosure:**

| | | | |
|---|---|---|---|
| ☐ Personal request | ☐ Insurance request | ☐ Legal request | ☐ Continuing Care |
| Other (Specify): | | | |

Patient Name: ______________________________________________
Surname First Name

Previous Surname: ______________________________Date of Birth:_______/________/_______
DD MM YYYY

Telephone: ____________________ Address: ______________________________

**Signature:**______________________________________________
**Signature Patient or Legally Authorized Representative** **(Relationship to Patient**

_______________________________ ______________________________________________
Date Signature of Witness

Consenter – The patient or person lawfully authorized to make treatment decisions on behalf of the incapable patient may sign the consent form. NOTE This consent will be valid for four (4) months. The individual who signed the consent may withdraw the consent at any time unless the disclosure has already been processed. Information disclosed is subject to possible re-disclosure by the receiving party which is beyond the control of the Hospital.

This form was developed in collaboration with Guelph General Hospital.

**Office Use Only - Proof of Identity:**

| | | |
|---|---|---|
| ☐ Driver's License | ☐ Health card (Photo ID) | ☐ Other |