Consent to the Disclosure of Personal Health Information

I ______________________ Consent to the disclosure of the following:

(Patient/SDM (Substitute Decision Maker)

Information pertaining to: (Detail of information to be released (dates, type of visit, other information as required)

Last Name	First Name	Date of Birth	Health Card Number

To: (Recipient)

Name	Company Name

Address	City	Province	Postal Code	Telephone #

Patient/SDM* consenting to the disclosure:

Last Name	First Name	Relationship if other than patient	Signature	Date (yy-mm-dd)

Contact Information

Address	City	Province	Country	Postal Code

Email	Telephone #	Fax #

*Authorized substitute decision-maker will be required to provide the documentation to satisfy the health information custodian.

Please provide one of the following pieces of ID to receive the requested information.

Please Note: There is an administrative fee associated with a request to view and/or obtain a photocopy of your health record.

☐ Driver's License ☐Passport ☐Health Card (with photo) ☐Notarized Letter

This Consent For Disclosure is valid for 6 months and pertains to the disclosure of information that is specific to treatment received on or before the date signed. It can be altered or withdrawn by the patient or SDM at any time by written notification to the hospital. Withdrawal of consent is not retroactive to information already disclosed.

Listowel Memorial Hospital Health Records Department 255 Elizabeth St. East Listowel, ON N4W 2P5 Phone: (519)291-3120 Ext. 6207 Fax: (519)292-2131	**Wingham and District Hospital** Health Records Department 270 Carling Terrace Wingham, ON, N0G 2W0 Phone: (519)357-3210 Ext. 5230 Fax: (519)357-3904