# CONSENT FOR ACCESS OR DISCLOSURE OF PERSONAL and/or PERSONAL HEALTH INFORMATION

**DATE: (DD/MM/YYYY)** _____

PIN # _____
(Hospital use only)

**I CONSENT TO ALLOW:** (check one only)

☐ Strathroy Middlesex General Hospital

☐ Four Counties Health Services

**TO ACCESS/DISCLOSURE THE FOLLOWING INFORMATION:** (specify dates of visits, contacts, hospitalization, treatment, or other information as required)

_____

_____

**PATIENT:**

Patient Name: _____ Date of Birth: _____
Last Name Given Name Middle Name (YYYY/MM/DD)

Address: _____

Email Address: _____ Telephone #: _____

**Person or Agency to Receive the Information:**

Name of Person or Agency: _____

Address: _____

Telephone #: _____ Fax #: _____

**I understand that this information is to be used by the recipient for the purpose of:** _____

_____

**Patient/client/resident or person (with legal signing authority) consenting to access/disclosure:**

Printed Name: _____ Signature: _____

Relationship if other than patient: _____

Address and Telephone # (if different than patient) _____

_____

**Office Use Only** – Verification of identity of individual consenting to the access/disclosure:

Form of ID: ☐ Driver's License ☐ Health Card ☐ Power of Attorney/Executor of Estate documentation
☐ Passport ☐ Other (specify): _____

**ID Checked by:** _____ _____
**Printed Name** **Signature**

**Please Note:** *This Request to Access for Disclosure form, is valid of 6 months and pertains to the 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 It can be altered or withdrawn by the patient or SDM at any time by written notification to the hospital.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.*