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

DATE: (DD/MM/YY) ______________________________

PIN # ________________
(for office use only)

I CONSENT TO ALLOW: (check one only)

☐ Strathroy Middlesex General Hospital

☐ Four Counties Health Services

☐ Other health facility, practitioner or agency (specify) ______________________________

TO ACCESS/DISCLOSE THE FOLLOWING INFORMATION: (If applicable, specify dates of visits, contacts, hospitalization, treatment, or other information required)

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CONCERNING:

Patient / Client Name: ______________________________ Date of Birth: ____________
Last Name Given Name Middle Name (YYYY / MM / DD)

Address: ____

____ Telephone #: ____________

Person / Agency to receive information: ______________________________

Address: ____ Telephone #: ____________

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/client/resident:
(if patient/client/resident is incapable or deceased)

Address & Telephone # if different than patient/client:

______________________ ______________________

Office Use only - Verification of identity of individual consenting to the access/disclosure:

Form of ID: ☐ Drivers Licence ☐ Passport ☐ Notarized letter/Lawyer's letter

☐ Other (specify) ______________________

ID Checked by ______________________ ______________________
Printed name Signature

<u>PLEASE NOTE:</u> This Consent For Access or Disclosure 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 It can be altered or withdrawn by the patient or alternate at any time by written notification to the hospital. Withdrawal of consent is not retroactive to information already released.