



Addressograph /  
Patient ID Label (Bar Code)

**CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION**

I \_\_\_\_\_  
Client/Patient Name: (Print Last Name, First Name)

hereby authorize the \_\_\_\_\_ to disclose personal health information  
Name of Person/Agency Disclosing Information

to \_\_\_\_\_  
Name of Person/Agency Requesting Information

of \_\_\_\_\_  
Street Address City Province Postal Code

from the records of:

\_\_\_\_\_ Date of Birth (dd/mm/yyyy) Health Card #

\_\_\_\_\_ Street Address City Province Postal Code

I consent to the following specific information to be disclosed (please check all appropriate items):

- Mental health/addictions admission history
- Medical history
- Other (Please Specify): \_\_\_\_\_
- Medical and psychiatric consultation reports
- Discharge summary
- Medications summary

Information is being released for the purpose of: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How may this information be released (choose all that apply)?  Verbally  Photocopy

\_\_\_\_\_ Signature of Witness \_\_\_\_\_ Signature of Client/Patient

\_\_\_\_\_ Print Name of Witness \_\_\_\_\_ (if other than client/patient, print name and state relationship)

Date: \_\_\_\_\_  
(dd/mm/yyyy)

Additional Instructions: \_\_\_\_\_  
\_\_\_\_\_

**This authorization may be withdrawn in writing at any time.**

All Consent for Disclosure of Personal Health Information forms must be delivered to the Health Records department to be processed. An administrative fee may be applied to cover photocopying and related costs.

**FOR INTERNAL HEALTH RECORDS/CLINICAL STAFF USE ONLY**

INFORMATION RELEASED BY:  Verbal Communication  Mail  Fax