CONSENT FOR DISCLOSURE OF HEALTH INFORMATION

Date _____

Patient/Resident/Client: _____ _____
(SURNAME) (FIRST NAME)

Personal Health #: _____ Date of Birth (DD/MM/YYYY) _____

I hereby authorize _____ to disclose my health/personal information
(Name of facility/clinical agency)

Information to be disclosed to (self or other, specific name and address of person/agency to whom information is to be disclosed):

_____

_____

Information to be disclosed (please be as specific as possible):

_____

_____

Reason for request
☐ Continuing patient care
☐ Self
☐ Other _____

Information will be picked up ☐ -or- Mail information to address below ☐

Address _____

I understand why I have been asked to disclose my individually identifying information, and I am aware of the risks or benefits of consenting, or refusing to consent, to the disclosure of my individually identifying information. I understand that I may revoke this consent in writing at any time. This consent expires one year from date of signature. A photocopy or facsimile of this consent shall be as valid as the original.

_____ _____
Signature of Patient/Authorized Representative Date
*Authorized Representative – attach a copy of your authority to act

_____
Signature of Witness

_____
Initial of Manager
(If required)

Pick-Up of Document(s)

_____
Signature of Patient/Authorized Representative

_____ Identification Verified ☐
Date