For office use only

Medical Record Number: ____________________

Account Number: ____________________

Log Number: ____________________

❒ prepayment received

Clinical Information Services
Authorization for Disclosure of
PERSONAL HEALTH INFORMATION

I hereby authorize Halton Healthcare (select all that apply):

❒ Oakville Trafalgar Memorial Hospital ❒ Milton District Hospital ❒ Georgetown Hospital

❒ **To release to:** ____________________
❒ **To collect from:** Patient, Family, SDM, Insurance, Law Firm, Other; include name, address and telephone number

the following records: ____________________
Description of records to be released and date range

____

From the record of:

____________________ Patient's Name ____________________ Date of Birth (DD/MM/YYYY)

____________________ Street Address ____________________ Health Card Number

____________________ City Province Postal Code ____________________ Phone Number

Reason for request: ❒ Health Care ❒ Personal Use ❒ Legal/ Lawyer ❒ Insurance ❒ Other ____________________
Specify

If COLLECTING records from another organization, please fax personal information back to:

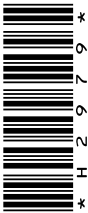
Unit: ____________________ Attention: ____________________

Phone Number: ____________________ Fax Number: ____________________

____
Signature of patient

____________________ ____________________
Signature of Substitute Decision Maker (if applicable) **Print name of SDM and relationship**

____________________ ____________________
Signature of witness **Print name of witness**



____
Date (DD/MM/YYYY)

This consent pertains to the disclosure of records for treatment received on or before the date signed and is valid for three (3) months.

**NOTE: In accordance with PHIPA (Personal Health Information Protection Act), authorization must be signed by the patient OR the substitute decision maker if the patient is certified incapable. A substitute decision-maker is a person authorized by PHIPA to consent on behalf of an individual, to disclose personal health information about the individual.