C R E D I T ▪ V A L L E Y
THE CREDIT VALLEY HOSPITAL

CONSENT TO DISCLOSE, TRANSMIT, ACCESS OR EXAMINE PERSONAL HEALTH INFORMATION

PURSUANT TO THE PERSONAL HEALTH INFORMATION PROTECTION ACT, 2004 (PHIPA)

I, ______________________________________, authorize ____
(Print your name)

to disclose personal health information belonging to: ☐ myself **OR** ☐ ______________________________
(Name of person for whom you are the SDM)*

date of birth ____ / ____ / ____, **concerning treatment from** ____ / ____ / ____, to ____ / ____ / ____,
dd mm yy *dd mm yy* *dd mm yy*

____
(Describe the personal health information to be disclosed)

____

This information may be disclosed to the following:

____
(Name) *(Phone Number)* *(Fax Number)*

____
(Address) *(City)* *(Postal Code)*

I understand this personal health information is to be used ONLY by the recipient for the purpose of:

____

I hereby waive any and all claims against The Credit Valley Hospital in connection with the disclosure of this personal health information.

My Name: ______________________________________ Contact #: ______________________________

Address: ____

Signature: ______________________________________ Date: ______________________________

Witness Name: __________________________________ Relationship: __________________________

Signature: ______________________________________ Date: ______________________________

*Note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.

Interpreter: I have done my best to accurately translate this form for the person referred to above, and will not divulge any information learned during this review.

Interpreter Name: ______________________________ Interpreter Signature: __________________________

HOSPITAL USE: Type of disclosure provided: ☐ ***photocopies*** ☐ **fax/scan** ☐ ***view*** ☐ ***other*** ____________________

Requestor ID verified: ____________________ **Fee quoted: $** ____________________

Hospital ID: __________________________ **Health Card Number:** __________________________

Subject to current fee schedule

Created in partnership by The Credit Valley Hospital, Trillium Health Centre and William Osler Health Centre

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