HEALTH RECORDS DEPARTMENT

75 Parkview Road, Hagersville, ON, N0A 1H0 **Ph:** 905-768-3311 Ext. 1175 / Ext. 1177 **Fax:** 905-768-4134

AUTHORIZATION FOR RELEASE OR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I, _____ hereby authorize the West Haldimand General Hospital, to disclose the following personal health information *(Please provide a description of the information to be disclosed)*: _____

_____

to: *(please provide the name, address, phone & fax numbers of the person/agency requesting the information)*

_____

_____

From the records of:

Name of Patient:_____ **Date of Birth (DD-MM-YYYY):**_____

Other Patient Info (HCN, Address, Phone Etc.):_____

_____

Dates of Hospitalization or Contact: _____

The Reason for this request is: €Circle of Care €Lawyer €Insurance €Personal Use

Other_____

I hereby waive any and all claims against the West Haldimand General Hospital in connection with the disclosure of this personal health information.

Signature *(patient or substitute decision-maker)*: _____

Print Name & Relationship *(if not signed by patient)*:_____

Signature of Witness: _____

Date (DD-MM-YYYY):_____ Contact Number: _____

Name *(if different than above)*: _____

Note: This authorization may be rescinded or amended in writing at any time prior to expiration date, except where action has been taken in reliance on the authorization.

ONLY AN ORIGINAL AUTHORIZATION WILL BE ACCEPTED