Health Records Tel. (705) 324-6111 Fax (705) 328-6156
10 Angeline St. N., Lindsay, Ontario K9V 4M8

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION FORM

I hereby authorize **ROSS MEMORIAL HOSPITAL**

To disclose the following personal health information: ____________________________

____

TO: ____

____

From the records of:
Name of Patient: ____

Birth date: __________________ **chart #**________________

Mailing Address of Patient: ____

____

____

I understand that this personal health information is to be used **only** by the above recipient for the purposes of: ____

Date: _____________________

I hereby waive any and all claims against **ROSS MEMORIAL'S HOSPITAL** in connection with the disclosure of this personal health information.

Signed by: ____
(Patient or Substitute Decision-Maker)

Date: ________________________________

Witness: ____
(Relationship to the Patient)