CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I, ______________________ , hereby authorize ______________________________________
(Print name) (Name of site or organization releasing information)

to release the following personal health information:

____

____

____
(Description of information to be disclosed including dates of hospital visits)

to ____

____

____
(Name and address of person/agency)

from the records of:

____
(Name of Patient) (Birth Date) (LH Unique #)

____
(Mailing Address)

I understand that this information is to be used only by the recipient for the purpose of:

____

____

Date: ______________________________ Expiry date: ______________________________
(3 months from date signed unless otherwise stated)

____
(Signature of Patient or Substitute Decision Maker)

Relationship
to the patient ________________________________
(If signed by Substitute Decision Maker)

Note: This authorization may be rescinded or amended in writing.