PRHC
Peterborough Regional Health Centre

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I _____ hereby authorize _____

to disclose the following personal health information:

_____

_____

_____

_____

(Description of personal health information to be disclosed and dates of contact/hospitalisation))

to

_____

_____

_____

(Name and address of person/agency requesting the information)

from the records of _____ _____
(Name of Patient) *(Date of Birth dd/mm/yy)*

_____
(*Address of Patient)*

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

_____

_____

_____

_____

I hereby waive any and all claims against Peterborough Regional Health Centre in connection with the disclosure of this personal health information.

Signed by: _____ Witness: _____
(Patient or Substitute Decision Maker)

_____ Date: _____
(Relationship to the Patient) (Day, Month, Year)

Ref. *Personal Health Information Protection (PHIPA) 2004*