



To: St. Michael's Hospital
Health Records Department - Release of Information
30 Bond Street
Toronto ON M5B 1W8
Phone: 416-864-5213 Fax: 416-864-5831

**Consent to Disclose Personal Health Information Form
Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)**

I _____ hereby authorize **St. Michael's Hospital**
(Patient's or Substitute Decision Maker's full name)

to disclose the following personal health information (please provide description and dates):

To Recipient:

Personal Lawyer Insurance Care provider Other: _____

The Recipient Name _____

Address: _____

Phone: _____ Fax: _____ Email: _____

from the health records of:

	(Patient Last Name)	(Patient First Name)
(Street Address)	(Home Phone #)	(Birth date)
(City, Province)	(Work Phone #)	(Medical Record #, if known)
(Postal Code)	(Ontario Health Number/Version Code)	

Print: Patient Name/Substitute Decision Maker

Print: Name of Witness

Signature and Relationship:

Signature of Witness:

Date:
(dd/mm/yyyy)

This authorization is valid for a period of 90 days from the date of signing and may be rescinded or amended in writing during that period except where action has been taken based on authorization provided. This authorization shall apply only to information dated prior to date of signature.