ST. MICHAEL'S
UNITY HEALTH TORONTO

Patient ID

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

_____

Signature and Relationship:

_____

Date:

_____
(dd/mm/yyyy)

Print: Name of Witness

_____

Signature of Witness:

_____

This authorization is valid for a period of 90 days from the date of signing and may be rescinded or amended in writing during that period except where action has been taken based on authorization provided.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