CAMPBELLFORD MEMORIAL HOSPITAL

# Consent to Disclose Personal Health Information

*Under the Personal Health Information Act (PHIPA)*

I, ______________________________ hereby authorize ____________________________

**(Print name)** **(Name of hospital or organization releasing the 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 requesting information)**

from the records of:

_______________________________________________________________

**(Name of Patient)** **(Birthdate – dd/mm/yy)**

__________________________________________________________________________

**(Mailing Address)**

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

________________ ___________________________ __________________

**(Date)** **(Signature of Patient of Substitute Decision-Maker)** **(Relationship to the patient if signed by the Substitute Decision Maker)**