

Consent for Disclosure of Personal Health Information

PATIENT INFORMATION		
Last Name:	First Name:	Initial
OHIP Number:	Date of Birth:	<i>(dd/mm/yyyy)</i>
Address: <i>(Street Name)</i>	Apt No.	
City:	Province/State:	Postal Code/Zip:
Phone: ()	Alternative Phone Number: ()	
<input type="checkbox"/> To obtain information from: _____ <div style="text-align: center;">And/OR</div> <input type="checkbox"/> Provide information to: _____		
REASON FOR REQUEST TO DISCLOSE PERSONAL HEALTH INFORMATION		
I understand this information is to be used by the recipient for the purpose of: <input type="checkbox"/> Self <input type="checkbox"/> Health Care Provider <input type="checkbox"/> Lawyer <input type="checkbox"/> Insurance <input type="checkbox"/> Other:		
PERSONAL HEALTH INFORMATION AUTHORIZED FOR RELEASE		
Document(s) Required	Date of Visit(s) <i>(dd/mm/yyyy)</i>	
Patient/Substitute Decision Maker/Executor (Print)	Signature	Date <i>(dd/mm/yyyy)</i>
Witness (Print)	Signature	Date <i>(dd/mm/yyyy)</i>
If the person signing is not the patient, please provide Mackenzie Health with documentation of your authority to obtain this information.		
FOR HOSPITAL USE ONLY		
Hospital Fee:	Medical Record#:	
Processing of this request is subject to administration fees. This consent for release of patient information may be withdrawn by the patient, substitute decision maker or executor in writing at any time.		
Please forward to Mackenzie Health		
Hospital Main#: (905) 883-1212	Unit Fax#: _____	



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