Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street
Richmond Hill, Ontario
L4C 4Z3

Consent For Disclosure Of Personal Health Information

PATIENT INFORMATION		
Last Name:	***First Name:***	***Initial***
OHIP Number:	***Date of Birth:***	*yyyy/mm/dd*
Address: Street Name		*Apt No.*
City	*Province/State*	*Postal Code/Zip*
Phone Number: ( )	**Alternate Phone Number:** ( )	

☐ To obtain information from: _____

And/OR

☐ 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:

☐ Self ☐ Health Care Provider ☐ Lawyer ☐ Insurance ☐ Other:

PERSONAL HEALTH INFORMATION AUTHORIZED FOR RELEASE

Document(s) Required	**Date of Visit(s)**

Patient/Substitute Decision Maker/Executor (Print)	Signature	Date *yyyy/mm/dd*
Witness (Print)	Signature	Date *yyyy/mm/dd*

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 This consent for release of patient information may be withdrawn by the patient, substitute decision maker or executor in writing at any time.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:

Health Information Services, 10 Trench Street, Richmond Hill, Ontario, L4C 4Z3
Telephone: (905) 883-2200 Fax: (905) 883-2141