Hamilton Health Sciences

For Internal Use Only – Pt. ID Number _____

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I _____ , hereby authorize Hamilton Health Sciences
Print Name

to disclose personal health information to: Name _____

Address _____ City _____ _____
Postal Code

Phone Number (____) _____ Fax Number (____) _____

concerning information from _____ to _____ at the following site(s):
year / month / day *year / month / day*

- ☐ Chedoke Hospital
- ☐ Hamilton General Hospital
- ☐ Juravinski Hospital
- ☐ Juravinski Cancer Centre
- ☐ McMaster Children's Hospital
- ☐ McMaster University Medical Centre
- ☐ Ron Joyce Children's Health Centre
- ☐ St. Peter's Hospital
- ☐ Urgent Care Center
- ☐ West Lincoln Memorial Hospital

An **Administration Fee** to cover the costs of processing requests is required. You will be notified of the cost of your request once calculated and before processing.

From the records of: _____ Date of Birth: _____
Print name of patient year / month / day

Health Card Number _____ Phone Number (____) _____ .

The type of personal health information to be disclosed is : _____

_____

_____ .

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

_____

I hereby waive any and all claims against Hamilton Health Sciences in connection with the disclosure of this personal health information.

_____	_____	_____
(year / month / day)	*Printed Name of Patient or Substitute Decision Maker*	*Signature of Patient or Substitute Decision Maker*

Witness Printed Name _____ _____

*If substitute decision maker, specify relationship to patient **and complete information on reverse***

Witness Signature _____

This form is valid for 90 days from date of signature

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Date: (yyyy/mm/dd) _____ **RE:** Patient Name: _____

Substitute Decision Maker Identification

Name: _____

Address and Phone Number: _____

_____

Relationship to Patient: _____

1. I am at least 16 years old or I am under 16 years and the parent of the incapable patient

2. I believe that the incapable patient, when capable, would not have objected to me deciding about the disclosure of health information.

3. I believe that no one ranking higher than me, or the same rank as me, claims authority and is available and willing to decide about the disclosure of personal health information.

Choose one of the following:

a) Court Appointed Guardian
b) Power of Attorney
c) Representative appointed by the Consent Capacity Board
d) Spouse or Partner
e) Parent of Child
f) Parent with a right of access
g) Brother or sister
h) Any other relative related by blood, marriage or adoption

Date (yyyy/mm/dd) _____ Signature of Substitute Decision Maker _____

Documentation supporting your legal authority in requesting Hamilton Health Sciences to disclose personal health information on behalf of the patient, must be submitted with this request.
(i.e. Power of Attorney, Estate Executor / Administrator, etc.)

STATEMENT BY INTERPRETER: I have done my best to accurately translate this form for the person requesting the release of information.

_____ _____ (_____) _____
Printed Name Signature Phone Number

Mail this completed form *(and any additional supporting documentation if required)* **to:**

Hamilton Health Sciences - P.O. Box 2000, Hamilton, ON L8N 3Z5
Attn: Release of Information Department - _____ Site *(site where you were treated)*

(or for West Lincoln Site only) Hamilton Health Sciences – West Lincoln Memorial Hospital Site
169 Main St. East, Grimsby, ON L3M 1P3
Attn: Release of Information Department

OR **Fax completed form** to the Release of Information Department*:*

General Site
(Barton St. East, Hamilton)
Phone: 905-521-2100 X 46264
Fax: 905-577-8024

St. Peter's Site
(Maplewood Avenue, Hamilton)
Phone: 905-521-2100 X 12216
Fax: 905-526-2065

Juravinski Hospital/Cancer Centre
(Concession Street, Hamilton)
Phone: 905-521-2100 X 63315
Fax: 905-575-6344

All Other Hamilton Locations
Phone: 905-521-2100 X 75123
Fax: 905-528-3828

West Lincoln Memorial Hospital *(Main Street, Grimsby)*
Phone:905-945-2253 X 360
Fax: 905-945-3125

(Patient / SDM is to keep a copy of this consent upon completion)