Hamilton Health Sciences

Withdrawal of Consent for Personal Health Information Use

For Internal Hospital Use Only

Patient ID: _____

Entered By: _____

Entered On: _____ (date)

_____ (time)

Concerning:

Patient / Client Name: _____ Date of Birth: _____
Last - Given - Middle year / month / day

Address: _____

Health Card Number _____ Telephone (_____) _____

I, (printed name) _____, the

- ☐ Patient **OR**
- ☐ Substitute Decision Maker **(complete SDM section on reverse)** **OR**
- ☐ Third party – Relationship to Patient: _____,

wish to withdraw my consent to any further use or disclosure by Hamilton Health Sciences of my personal health information for: (*please check all that apply*)

- ☐ Fundraising
- ☐ Teaching
- ☐ Notification to a representative of a religious or other organization
- ☐ Conducting patient satisfaction surveys
- ☐ Confirmation that I am a patient, my general health status and my room and telephone extension while in hospital

_____ _____

Date (year / month / day) Signature

PLEASE NOTE: The withdrawal of consent does not have retroactive effect, nor does it affect the uses and disclosures of personal health information collected by Hamilton Health Sciences where the uses and disclosures are permitted or required by law without consent.

Please return to:
Privacy and Freedom of Information Office
Hamilton Health Sciences – King West
P.O. Box 2000, Hamilton, ON L8N 3Z5
Tel - 905-521-2100 ext 75122
Fax - 905-577-8474

Hamilton Health Sciences

Withdrawal of Consent for Personal Health Information Use

For Internal Hospital Use Only

Patient ID: _____

Entered By: _____

Entered On: _____ (date)

_____ (time)

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 or 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.)