



Consent for Disclosure of Personal Health Information

Clearly Imprint Patient Identification

Health Records Services

600 University Avenue, Suite 460
Toronto, Ontario, Canada M5G 1X5
Telephone: (416) 586-4800, Extension 2651
Fax: (416) 586-3181
Web Site: www.mtsinai.on.ca

Form MS704 (01.2005)

Patient/Client Name _____ Date of Birth _____
LAST NAME FIRST NAME INITIAL (YYYY MM DD)

Address _____

City _____ Province _____ Postal Code _____

Residential Telephone # (_____) _____ Business Telephone # (_____) _____

I authorize/request _____ to disclose patient/client personal health information to:

Name of Third Party/Health Care Institution/Health Care Provider _____

Address _____

City _____ Province _____ Postal Code _____

Telephone # (_____) _____ Fax # (_____) _____

Personal health information relating to: *(specify health information)* _____

Personal health information relating to the following treatment or admission:

Date(s) of Visit: 1. Admission date _____ <small>(YYYY MM DD)</small>	2. Admission date _____ <small>(YYYY MM DD)</small>	3. Admission date _____ <small>(YYYY MM DD)</small>
Discharge date _____ <small>(YYYY MM DD)</small>	Discharge date _____ <small>(YYYY MM DD)</small>	Discharge date _____ <small>(YYYY MM DD)</small>

- The reason for this request is: Further medical treatment Lawyer
- WSIB Estate settlement
- Insurance Other _____

- I understand the purpose for disclosing this personal health information to the person noted above.
- I understand that I can refuse to sign this Consent Form.

SIGNATURE OF PATIENT or SUBSTITUTE DECISION MAKER

SIGNATURE OF WITNESS

DATE (YYYY MM DD)

If the person signing is not the Patient, please state the relationship and authority to do so.

RELATIONSHIP TO PATIENT

AUTHORITY (i.e., Power of Attorney, Next of Kin, etc.)

**This authorization will be valid for a three month period as of the date of signature unless specified otherwise.
The authorization may be withdrawn in writing at any time.**

