Queensway Carleton Hospital

HEALTH RECORDS DEPARTMENT
CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

Name: _____ **DOB:** _____

UPI #: _____ **Phone #:** _____

Address: _____

I hereby authorize Queensway-Carleton Hospital to disclose the following health information:

_____

_____
(Description of personal health information to be disclosed and dates of contact/hospitalization)

to: _____

_____
(Name and address of person/agency requesting information)

from the records of _____
(Name of Patient) (Date of Birth)

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

☐ **Continuing Care** ☐ **Insurance** ☐ **Legal Purposes** ☐ **Other (Specify):**

_____

I hereby waive any and all claims against Queensway Carleton Hospital in connection with the disclosure of this personal health information.

_____ **Signature**: _____
(Relationship if signed by other then the patient) (Patient or Substitute Decision-Maker)

Date: _____ **Witness:** _____
(Expires within 60 days)

Note: 1. This authorization must contain the original signature of:
- **a) the patient**
- **b) the parent / legal guardian if the patient is under 16 years of age and unmarried; or**
- **c) the legal representative or Substitute Decision-Maker for the patient; and**
- **d) the witness to the patient's signature**

2. This authorization may be rescinded or amended in writing at any time except where action has been taken in reliance on this authorization.