APPENDIX B

CONSENT FOR ACCESS OR DISCLOSURE OF PERSONAL INFORMATION and/or PERSONAL HEALTH INFORMATION

DATE: (DD/MM/YY) _____

SH# _____
(for SHHA office use only)

I CONSENT TO ALLOW: (check ✓ one only)

☐ South Huron Hospital Association

☐ Other health facility, practitioner or agency (specify) _____

TO ACCESS/DISCLOSE THE FOLLOWING INFORMATION: (If applicable, specify dates of visits, contacts, hospitalization, treatment, or other information required)

_____

_____

CONCERNING:

Patient / Client Name: _____ Date of Birth: _____
Last Name Given Name Middle Name (DD / MM / YYYY)

Address: _____

_____ Telephone #: _____

Person / Agency to receive information: _____

Address: _____ Telephone #: _____

I understand that this information is to be used by the Recipient for the purpose of:

_____

Patient/client/resident or person (with legal signing authority) consenting to access/disclosure:

Printed Name: _____ Signature: _____

Relationship if other than patient/client/resident**:**
(If patient/client/resident is incapable or deceased)

Address & Telephone # if different than patient/client

_____ _____

Office Use only - Verification of identity of individual consenting to the access/disclosure:

Form of ID: ❑ Drivers License ❑ Passport ❑ Notarized letter/Lawyer's letter

❑ Other (specify) _____

ID Checked by _____ _____
Printed name Signature

PLEASE NOTE: This Consent For Access or Disclosure pertains to the disclosure of information that is specific to treatment received on or before the date signed. It can be altered or withdrawn by the patient or alternate at any time by written notification to the hospital. Withdrawal of consent is not retroactive to information already released.