Hamilton Niagara Haldimand Brant **LHIN** | **RLISS** de Hamilton Niagara Haldimand Brant

Consent to Release My Personal Health Information

PART A: PATIENT INFORMATION

Last Name _____ **First Name** _____

Date of Birth (yyyy/mm/dd) _____ **Health Card Number** _____

PART B: REQUEST FOR INFORMATION

Please describe what information you require (e.g. complete or partial health record, service provider reports, assessments, service confirmation letter, etc.)

_____

This information may be released to:

Name and/or Organization _____

Mailing Address _____

Telephone Number _____ **Fax Number** _____

PART C: AUTHORIZATION

By signing this form, I understand I am giving my permission to the HNHB LHIN to release my personal health information to the above-named individual or organization. I understand that I may cancel or amend this authorization in writing at any time.

Signature of Patient, Substitute Decision Maker or Power of Attorney for Personal Care _____ **Name** _____ **Date (yyyy/mm/dd)** _____

Please forward the completed form to Attention Health Records	
FAX	**MAILING ADDRESS**
905-574-5148	211 Pritchard Road, Unit 1 Hamilton, ON, L8J 0G5
If required, please include copies of documents showing you have authority to provide consent e.g. Power of Attorney for Personal Care, copy of the Will, Certificate of Appointment of Estate Trustee, etc.	

All patients have the right to access their personal health record in accordance to the Personal Health Information Protection Act, 2004. This consent is valid for 90 days starting from the signed date. This authorization may be cancelled or amended at any time.

Ontario