Mackenzie Health

Mackenzie Richmond Hill Hospital
10 Trench Street, Richmond Hill ON L4C 4Z3
905-883-1212

Cortellucci Vaughan Hospital
3200 Major Mackenzie Drive West, Vaughan ON L6A 4Z3
905-417-2000

Consent for Disclosure of Personal Health Information

PATIENT INFORMATION		
Last Name:	***First Name:***	***Initial***
OHIP#:	***Date of Birth:***	***(dd/mm/yyyy)***
Address:		
City:	***Province/State:***	***Postal/Zip Code:***
Phone Number: ( )	***Alternate Phone Number: ( )***	

❑ To obtain information from: _____

And/Or

❑ Provide Information to: _____

Please complete the below information if the recipient is not the patient

Recipient Name:	Recipient Address:
Recipient Phone#:	Recipient Fax#:

REASON FOR REQUEST TO DISCLOSE PERSONAL HEALTH INFORMATION

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

❑ Self ❑ Health care provider ❑ Lawyer ❑ Insurance ❑ Other: _____

PERSONAL HEALTH INFORMATION AUTHORIZED FOR RELEASE

Document(s) required:	**Date of visit(s)**

Patient/Substitute Decision Maker/Executor (Print)	Signature	Date (dd/mm/yyyy)
Witness (Print)	Signature	Date (dd/mm/yyyy)

IMPORTANT: If the person signing is not the patient, please provide Mackenzie Health with documentation of your authority to obtain this information.

Processing this request is subject to administration fees.

This consent for release of patient information may be withdrawn by the patient/SDM/executor in writing at any time.

FOR HOSPITAL USE ONLY

Hospital Fees:	**Medical Record Number (MRN):**

Please forward to Mackenzie Health

Hospital Telephone: (905) 883-1212 **Fax# (905) 883-2141** **Unit Fax#: _____**