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 Number:	**Date of Birth:**	**(dd/mm/yyyy)**
Address: ***(Street Name)***		***Apt No.***
City:	**Province/State:**	**Postal Code/Zip:**
Phone: ( )	**Alternative Phone Number: ( )**	

☐ To obtain information from: _____

And/OR

☐ Provide information to: _____

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)** (dd/mm/yyyy)

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

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

FOR HOSPITAL USE ONLY

Hospital Fee:	**Medical Record#:**

Processing of this request is subject to administration fees. This consent for release of patient information may be withdrawn by the patient, substitute decision maker or executor in writing at any time.

Please forward to Mackenzie Health

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

(Feb 2007, Rev. Nov 2013)