Manual: Admin

No: 5E-6-F-1

RUNNYMEDE
HEALTHCARE CENTRE

625 Runnymede Road
Toronto, Ontario, M6S 3A3
Phone: 416-762-7316
Fax: 416-762-3836

CONSENT TO THE COLLECTION, USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

I ____________________________ hereby authorize __________________________
(Name of hospital/physician's office)

to disclose the following personal 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) **(Birth date)**

Mailing Address of Patient: ____

____

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

____

____

I hereby waive any and all claims against Runnymede Healthcare Centre in connection with the disclosure of this personal health information.

Name (print):________________________________ Signature:________________________________

Self ______ or Substitute Decision Maker ______ Relationship:______________________________

Witness:___________________________________ Date: ___________________________________