Hamilton Health Sciences

For Internal Use Only – Pt. ID Number _____

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

Date *(year/month/day)* _____

I consent to Hamilton Health Sciences disclosing information from _____ to _____ at the following site(s):
year / month / day year / month / day

- ☐ Chedoke Hospital
- ☐ Juravinski Hospital
- ☐ McMaster Children's Hospital
- ☐ Ron Joyce Children's Health Centre
- ☐ Urgent Care Center
- ☐ Hamilton General Hospital
- ☐ Juravinski Cancer Centre
- ☐ McMaster University Medical Centre
- ☐ St. Peter's Hospital
- ☐ West Lincoln Memorial Hospital

An **Administration Fee** to cover the costs of processing requests is required. You will be notified of the cost of your request once calculated and before processing.

The type of information to be disclosed is: _____

_____

Concerning:

Patient / Client Name: _____ Date of Birth: _____
Last - Given - Middle year / month / day

Address: _____

Health Card Number _____ Telephone (_____) _____

Person / Agency to receive information (if other than the patient):

Name and Address _____

_____

Telephone (_____) _____ Fax (_____) _____

I understand that this information is to be used by the Recipient (if someone other than the Patient) for the purpose of:

_____

AUTHORIZATION:

- ☐ I am the patient requesting my own records
- ☐ I am the Substitute Decision Maker **(complete SDM section on reverse)**
- ☐ I am a third party – Relationship to Patient: _____

_____	_____	_____
Printed Name	Signature	Date (year / month / day)
_____	_____	_____
Witness - Printed Name	Signature	Date (year / month / day)

STATEMENT BY INTERPRETER: I have done my best to accurately translate this form from English to (indicate language) _____ and will not divulge any information.

_____	_____	_____
Printed Name	Signature	Date (year / month / day)

This form is valid for 90 days from date of signature

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CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

Date: (yyyy/mm/dd) _____ **RE:** Patient Name: _____

Substitute Decision Maker Identification

Name: _____

Address and Phone Number: _____

_____

Relationship to Patient: _____

1. I am at least 16 years old or I am under 16 years and the parent of the incapable patient

2. I believe that the incapable patient, when capable, would not have objected to me deciding about the disclosure of health information.

3. I believe that no one ranking higher than me, or the same rank as me, claims authority and is available and willing to decide about the disclosure of personal health information.

Choose one of the following:

a) Court Appointed Guardian
b) Power of Attorney
c) Representative appointed by the Consent Capacity Board
d) Spouse or Partner
e) Parent or Child
f) Parent with a right of access
g) Brother or sister
h) Any other relative related by blood, marriage or adoption

Date (yyyy/mm/dd) _____ Signature of Substitute Decision Maker _____

Documentation supporting your legal authority in requesting Hamilton Health Sciences to disclose personal health information on behalf of the patient, must be submitted with this request.
(i.e. Power of Attorney, Estate Executor / Administrator, etc.)

Mail this completed form *(and any additional supporting documentation if required)* **to:**

West Lincoln Site → Hamilton Health Sciences – West Lincoln Memorial Hospital Site
169 Main St. East, Grimsby, ON L3M 1P3 Attn: Release of Information Department

All Other Sites → Hamilton Health Sciences - P.O. Box 2000, Hamilton, ON L8N 3Z5
Attn: Release of Information Department - _____ Site

Please indicate the site where you were treated, using one of the following:
• General • St. Peters • Juravinski **or** for all other Hamilton Locations, state • MUMC

OR Scan completed form and email to**: releaseofinfo@hhsc.ca**

OR Fax completed form to the Release of Information Department*:*

Hamilton General Hospital
(Barton St. East, Hamilton)
Phone: 905-521-2100 X 46264
Fax: 905-577-8024

St. Peter's Hospital
(Maplewood Avenue, Hamilton)
Phone: 905-521-2100 X 12216
Fax: 905-526-2065

Juravinski Hospital/Cancer Centre
(Concession Street, Hamilton)
Phone: 905-521-2100 X 63315
Fax: 905-575-6344

West Lincoln Memorial Hospital
(Main Street, Grimsby)
Phone:905-945-2253 X 11360
Fax: 905-945-3125

CHED/UCC/MCH/MUMC/RJCHC:
• Chedoke Hospital
• Urgent Care Center
Phone: 905-521-2100 X 75123

• McMaster Children's Hospital
• McMaster University Med. Centre
• Ron Joyce Children's Health Centre
Fax: 905-528-3828

(The person submitting this request, is to keep a copy of this consent upon completion)