SHN
SCARBOROUGH HEALTH NETWORK

AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

844272

Last Name_____ First Name _____

Date of Birth_____ OHIP Number _____

Street Name_____ Apt # _____

City_____ Country_____ Postal Code _____

Telephone # _____

REASON FOR REQUEST AND RELEASE OF INFORMATION

❑ Self ❑ Healthcare Provider ❑ Lawyer ❑ Insurance ❑ WSIB ❑ Other (Please Specify)_____

I Hereby Authorize _____To Release My Personal Health Information to:

Name of Health Care Provider/Third Party _____ Unit/Dept_____

Street Name_____ Apt # _____

City _____Country_____ Postal Code _____

Telephone # _____ Ext_____ Fax # _____

(Description of Personal Health Information to be disclosed and dates of hospitalization)

❑ Emergency visit on:_____

❑ Outpatient visit on:_____

❑ Inpatient visit from:_____

❑ CD from Diagnostic Imaging: _____

_____ _____ _____

Patient or Substitute Decision Maker or Executor (Print Name) Signature Date (dd/mm/yy)

_____ _____ _____

Witness (Print Name) Signature Date (dd/mm/yy)

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

Faxed Authorization from Circle of Care to Release Personal Health Information are accepted. **NOTE:** Records pick up for personal request requires a valid government issued photo ID.

Important

A 'non refundable' administration fee of $30.00 (includes first 20 pages) is required to initiate processing of request.
For Diagnostic Imaging CD, an additional fee of $10.00 will be charged.

For Health Records Use Only

MRN_____ ID Validated by (Initials) _____ Fee $_____

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