



HORNEPAYNE COMMUNITY HOSPITAL

P.O. BOX 190, 278 FRONT STREET, HORNEPAYNE, ONTARIO P0M 1Z0 (807) 868-2442 FAX: (807) 868-3097

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I, _____ hereby authorize _____

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 _____

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

I hereby waive any and all claims against the Hornepayne Community Hospital in connection with the disclosure of this personal health information.

Witness _____ Signed by _____

Date _____ (Relationship to the patient)