CAMPBELLFORD MEMORIAL HOSPITAL

CONSENT TO DISCLOSE
PERSONAL HEALTH INFORMATION FORM

I, _____ hereby authorize _____
(Name of patient or substitute decision-maker) **(Name of hospital/person/agency releasing the information)**

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) **(Birthdate – dd/mm/yy)**

_____
(Address of Patient – Street/Apt. No./P.O. Box/R.R. No.)

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 Campbellford Memorial Hospital in connection with the disclosure of this personal health information.

Signed by: _____ _____
(Patient or Substitute Decision-Maker) **(Relationship to the Patient)**

Witness: _____ Date: _____