GRAND RIVER HOSPITAL

835 King Street West, P.O. Box 9056
Kitchener Ontario N2G 1G3
Tel: 519-749-4300
www.grandriverhospital.on.ca

PATIENT AUTHORIZATION FOR THE COLLECTION/RELEASE OF PERSONAL HEALTH INFORMATION

Authorization must be signed by the patient or by the legally authorized representative in the case of incompetency or death.

I, ______________________________ hereby authorize
(Name of Patient/Substitute Decision Maker)

GRAND RIVER HOSPITAL to ☐ **Release** ☐ **Collect**

Records pertaining to the admission(s)/ visit(s) from______________ to ______________
(yyyy/mm/dd) (yyyy/mm/dd

compiled at: ______________________________
(Institution)

from the health record of: ______________________________ ______________________________
(Patient Name) (Date of Birth, yyyy/mm/dd)

Contact Phone #: ______________________________ ______________________________
Leave Message: Yes ☐ No ☐ (Health Card Number/ Photo ID)

REQUEST:

Requested by (Specific Name, Unit or Dept.): ______________________________

Requestor Agency Name & Department: ______________________________
(e.g. Insurance Company, Lawyer, Physician Office)

Address: ______________________________

PURPOSE:

This information will be used for the purpose of:

- ☐ Further medical treatment
- ☐ Insurance claim
- ☐ Litigation
- ☐ Estate settlement
- ☐ Physician Reference
- ☐ Mental Health Assessment &/Treatment
- ☐ Other ______________________________

CONSENT:

I understand the private and confidential nature of this information and agree that it will be used only for the stated purpose(s). I further absolve the information – releasing Hospital named above of any responsibility for carrying out this directive. This authorization will be valid for 90 days as of the date of signature, unless specified otherwise. I understand that I may withdraw my consent at any time by informing my Grand River Hospital contact.

Date of Consent: ______________________________ Signed: ______________________________

Consent Expiry Date: ______________________________ ______________________________
(Date) **(Relationship if other than patient)**

Witness: ______________________________ Print Name: ______________________________
(Signature)