ESHC ERIE SHORES HEALTHCARE
194 Talbot Street West, Leamington, Ontario N8H 1N9
(519) 326-2373

AUTHORIZATION TO DISCLOSE PERSONAL HEALTH INFORMATION

I _____ hereby authorize ERIE SHORES HEALTHCARE to disclose the following personal health information:

_____

_____
(Description of personal health information to be disclosed & dates of contact/hospitalization)

to: _____

_____
(Name and address of person/agency requesting the information)

from the records of _____
(Name of Patient) (Birth Date)

Mailing Address of Patient: _____

_____

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

_____

Date: _____ (mm/dd/yyyy) Expiry Date of Authorization: _____ (Not to exceed 3 months)

I hereby waive any and all claims against Erie Shores Healthcare in connection with the disclosure of this personal health information.

Signature Patient / Substitute Decision Maker (SDM) Please PRINT Name Date (mm/dd/yyyy)

Signature Witness Please PRINT Name Date (mm/dd/yyyy)

Relationship to Patient for SDM Signing:

Parent ☐ Legal Guardian* ☐ Power of Attorney* ☐

Legally Appointed Designate* ☐ SDM (please specify) ☐

*Please provide a copy of the supporting documents IE: POA, estate trustee, etc....

FOR ESHC USE ONLY
IDENTIFICATION VERIFIED YES ☐ NO ☐

Note: 1. This authorization must contain the Original signature of:
(a) the patient
the parent or legal guardian if the patient is under 16 years of age and unmarried: or
the legal representative of the patient if deceased or has been certified mentally incompetent:
and
b) the witness of the patient's signature

2. This authorization may be rescinded or amended in writing at any time prior to the expiration date, except where action has been in reliance on the authorization.

3. This authorization is valid to release information held under the Mental Health Act (formerly Form 14)

Date Complete Authorization Received: _____ (mm/dd/yyyy)

REL-INFO