CAMBRIDGE MEMORIAL HOSPITAL
700 Coronation Blvd.,
Cambridge, Ontario N1R 3G2
Tel: (519) 621-2330

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I _____ hereby authorize Cambridge Memorial Hospital 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, Day/Month/Year)

Mailing Address of Patient: _____

_____

Telephone #: _____

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

Witness: _____ Signed by: _____

(Patient or Substitute Decision Maker)

Date: _____ _____

(Relationship to Patient)