Hôpital Régional de Pembroke Regional Hospital

Addressograph

CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION TO A THIRD PARTY

I _____ hereby authorize _____
(Name of person/facility)

to disclose personal health information of: _____ _____
(Name of patient) (Date of birth)

_____
(description of personal health information requested)

to _____
(name and address of person/facility requesting information)

Specify information to be disclosed:
❑ verbally ❑ copies of record of personal health information

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

❑ Continuing Care ❑ Insurance ❑ Legal Purposes ❑ Other (Specify)

_____

_____

I hereby waive any and all claims against:

_____
(name of facility releasing information)

in connection with the disclosure of this personal health information.

Witness: _____ Signed by: _____
(Patient or Substitute Decision-Maker)

Date: _____ _____
(Relationship to Patient)

This form remains valid for 90 days from the date it is dated and signed by the patient or Substitute Decision-Maker.