North Bay Regional Health Centre | Centre régional de santé de North Bay

Consent for Release of Personal Health Information

Patient Information

Last Name:		First Name:	Initial:
No.:	Street Name:		Apartment No.:
City:		Province/State:	Country:
Postal Code/Zip:		Date of Birth:	Gender:
Contact Number - Area Code & Number:	Extension:	Alternate Number - Area Code & Number:	Extension:

Reason For Request and Release of Information

❑ Self ❑ Health Care Provider ❑ Lawyer ❑ Insurance ❑ WSIB ❑ Other:_____

The undersigned hereby requests North Bay Regional Health Centre to release/obtain my personal health information to:

Name of Health Care Provider / Third Party:

No.:	Street Name:			Apartment No.:
City:			Province/State:	
Country:			Postal Code/Zip:	
Contact Number:	Area Code & Number:	Extension:	Fax #:	Area Code & Number:

Personal Health Information Authorized for Release

Document(s) Required:	Date of Visit(s):

*** Substitute Decision Maker (SDM) must provide the hospital with authorizing documentation.**

Date: _____

Day / Month / Year

Patient/SDM: *****

_____ _____

(*Signature*) *(Please print name)*

Witness: _____ _____

(Signature) *(Please print name)*

FOR HOSPITAL USE ONLY	
Hospital Fee:	Medical Record #

Personal information contained in this form is collected in accordance with the *Freedom of Information and Protection of Privacy Act* for the purpose of consenting to disclosure of personal health information.
Questions about this collection can be directed to the Manager, Clinical Records Department 705-474-8600 ext 2655.

Please forward to: North Bay Regional Health Centre–Clinical Records Department, 50 College Drive, North Bay, ON P1B 0A4 - Phone: (705) 474-8600 x2660 – Fax: (705) 495-7931