Hôpital général de la baie Georgienne
GEORGIAN BAY
General Hospital

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I, _____, authorize Georgian Bay General Hospital to disclose the following personal health information:

_____

_____

(Description of personal health information to be disclosed and dates of contacl/hospitali1.at.ion)

to _____

_____

(Name and address of person/agency requesting 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 purposes of:

_____

_____

Date: _____

I hereby waive any and all claims against **Georgian Bay General Hospital** in connection with the disclosure of this personal health information.

Witness: ..... Signed by: _____

(Patient or Substitute Decision-Maker)

Date: _____

_____

(Relationship to the Patient)

To submit this request form, please fax a copy to Health Records at 705-526-4491.