GUELPH GENERAL HOSPITAL

UNIT NUMBER: _____

Consent to Disclosure of Personal Health Information

I hereby authorize Guelph General Hospital to disclose the below requested information to the following individual/organization. I authorize the disclosure of personal health information in either paper form or via email. I understand that e-mail is not a secure method of communication and therefore Guelph General Hospital (GGH) cannot guarantee the security of messages sent by this method and does not accept any legal liability in this transmission of information.

RELEASE TO: _____

(Name of institution, agency or person)

_____

(Address of recipient)

Visit/Assessments Dates: _____

Specify Information tobe released:

☐ Emergency Record	☐ Pathology report	☐ Audiology Notes
☐ History and Physical	☐ Laboratory report(s)	☐ Physiotherapy Report
☐ Consultation	☐ Radiology report(s) including ultrasound	☐ Social Work Report
☐ Discharge Summary	☐ Radiology images including ultrasound	☐ Psychosocial Report
☐ Operative Report	☐ ECG (s)	☐ COVID-19 Result
Other: (please specify)		

Purpose of the disclosure:

☐ Personal request	☐ Insurance request	☐ Legal request	☐ Continuing Care
Other (Specify):			

Patient Name: _____

Surname First Name

Previous Surname: _____ Date of Birth: ____/____/____

DD MM YYYY

Telephone: _____ Address: _____

Email Address: _____

Name of person requesting/authorizing release: _____ Contact Number: _____

Signature: _____

Signature Patient or Legally Authorized Representative (Relationship to Patient

_____

Date

Please fax request to:
519-837-6467

Please email request to:
ROI@gghorg.ca

Consenter – The patient or person lawfully authorized to make treatment decisions on behalf of the incapable patient may sign the consent form.
NOTE This consent will be valid for four (4) months. The individual who signed the consent may withdraw the consent at any time unless the disclosure has already been processed. Information disclosed is subject to possible re-disclosure by the receiving party, which is beyond the control of the Hospital.

Office Use Only - Proof of Identity:

☐ Driver's License	☐ Health card (Photo ID)	☐ Other