



CONSENT TO THE DISCLOSURE, TRANSMITTAL OR EXAMINATION OF PERSONAL HEALTH INFORMATION

I, _____, hereby, authorize
Patient Name or legal representative

_____ Health Care or Health Service Provider
to release health information from

_____my health record OR _____the health record of:

Patient's Name: _____ Date of Birth _____
Last Name First Name (DD/MM/YY)

Address: _____

to: _____
Name and address of third Party

Purpose for which information is disclosed: _____

Information requested: _____

I hereby waive any and all claims against Toronto Grace Health Centre in connection with the disclosure of this personal health information

Signature of Patient Signature of Witness Date (dd/mm/yy)

If the person signing is not the patient, state relationship and authority to do so.

Signature of Legal Representative Relationship Name of Witness (Please print) Date (dd/mm/yy)