



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)