

AUTHORIZATON FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

Patient Information			
Last Name:	First Name:	Initial:	
Date of Birth (MM/DD/YYYY):	Telephone #:		
Address:			
City:	Postal Code:		

Identification of Recipients	
Name of Recipient:	Relationship to Patient:
Name of Recipient:	Relationship to Patient:
Name of Recipient:	Relationship to Patient:

Patient Consent to Access/Disclosure	
Patient Name: _____	
I authorize Mount Dennis Weston Health Centre to disclose the health information to the recipient(s) above.	
This authorization will remain in effect until revoked in writing. To limit the duration of this authorization, please specify end date in next box.	End Date:
Signature:	Date:
Witness:	Date:

Office Use Only: Verification of identity of individual consenting to access/disclosure
Picture ID (requires one): ☐ HC ☐ Driver's License ☐ Passport
Other ID (requires 2) ☐ Citizenship/birth cert ☐ Other (specify): _____
SDM record check:
ID checked by: _____
Printed Name
Signature