Royal Victoria
Regional Health Centre

Hospital Unit #_____

Account # _____

OFFICE USE ONLY

CONSENT TO DISCLOSE
PERSONAL HEALTH INFORMATION FORM

I _____ hereby authorize The Royal Victoria Regional Health Centre to disclose the following personal health information:

_____

_____
(Description of personal health information to be disclosed and dates of contact/hospitalization)

to _____

_____
(Name and address of person/agency requesting information)

from the records of _____
(Name of Patient) (Birth date)

Mailing Address of Patient: _____

_____
(City/Town) (Postal Code)

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 The Royal Victoria Regional Health Centre in connection with the disclosure of this personal health information.

_____ _____
Signature of Patient or Substitute Decision Maker Relationship to the Patient

_____ _____
Witness Date (dd/mm/yy)

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www.rvh.on.ca

Inspiring care...