

CONSENT FOR RELEASE OF PERSONAL HEALTH INFORMATION

PATIENT INFORMATION									
Last Name					First Name			Init	
No.		Street Name					Apt No.		
City					Province/State				
Country						Postal Code/ZIP			
Contact #:		Area	Number	Ext.	OHIP Number:				
Alternate #:		Area	Number	Ext.	Date of Birth:		DD	MMM	YYYY
REASON FOR REQUEST AND RELEASE INFORMATION									
<input type="checkbox"/> Self <input type="checkbox"/> Health Care Provider <input type="checkbox"/> Lawyer <input type="checkbox"/> Insurance <input type="checkbox"/> WSIB <input type="checkbox"/> Other:									
The undersigned hereby requests North York General to release my personal health information to:									
Name of Health Care Provider / Third Party									
No.		Street Name					Apt No.		
City					Province/State				
Country						Postal Code/ZIP			
Contact #:		Area	Number	Ext.	Fax #:		Area	Number	
PERSONAL HEALTH INFORMATION AUTHORIZED FOR RELEASE									
Document(s) Required						Date of Visit(s)			
Patient/Substitute Decision Maker/Executor (Print)				Signature				Date	
Witness (Print)				Signature				Date	
If the person signing is not the patient, please provide NYGH with documentation of your authority to obtain this information.									
FOR HOSPITAL USE ONLY									
Hospital Fee:					Medical Record #:				
Processing of this request is subject to administration fees. This consent for release of patient information may be withdrawn by the patient, substitute decision maker or executor in writing at any time.									
Please Forward to: Release of Patient Information, North York General, 4001 Leslie Street, 1W-Rm.118, Toronto, Ontario, M2K 1E1 Phone: (416) 756 - 6209, Fax (416) 756-6705									