

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 This consent for release of patient information may be withdrawn by the patient, substitute decision maker or executor in writing at any time. Although withdrawn, fees are still applicable. Please note: Duplicate chart documentation may be generated if/when it relates to multiple visits and therefore forms part of the legal chart for those specific visits. Standard page charges apply.									
Please Forward to: Release of Patient Information, North York General, 4001 Leslie Street, Toronto, Ontario, M2K 1E1 Phone: (416) 756 - 6209, Fax (416) 756-6705									
Request #:									