St. Joseph's Healthcare Hamilton

Authorization for Disclosure of Personal Health Information

Information and Instructions

1. This authorization is valid for three (3) months from date of signature and must contain:
   - the original signature of the patient or substitute decision maker (SDM)
   - the legal representative if the patient is deceased
   - the signature of the witness to the patient or SDM signature
2. Requests for release of information must be dated after treatment dates.
3. Deliver completed request to appropriate Release of Information Specialist (address below)

For information about our privacy protection practices visit our website at www.stjoes.ca/privacy

Patient Identification

Name: _____ Date of Birth: _____
First Last yyyy/mm/dd

Address: _____
Street City Postal Code

I the undersigned authorize: _____ to
Print name of Health Information Custodian/Facility

Disclose personal health information to:

_____
Print Name and address of person/facility requesting the information

_____ _____ _____
Address City Postal Code

Purpose of Disclosure: ❑ Healthcare ❑ Legal Proceeding ❑ Insurance

❑ Other: _____

The Personal Health Information I authorize to be disclosed:

❑ Discharge Summary:

❑ Information Relating to: _____

❑ Other: _____

_____	_____	_____
Signature	Print Name	Relationship to Patient (state relationship which authorizes this consent to disclose)
_____	_____	_____
Witness Signature	Print Name	Date (yyyy/mm/dd)

THIS AUTHORIZATION MAY BE RESCINDED OR AMENDED IN WRITING AT ANY TIME PRIOR TO THE EXPIRATION DATE (3 MONTHS) EXCEPT WHERE ACTION HAS BEEN TAKEN IN RELIANCE ON THIS AUTHORIZATION

Charlton Campus
50 Charlton Ave., East
Hamilton, ON, Canada L8N 4A6
Tel: 905.522.1155

King Campus
2757 King Street East
Hamilton, ON, Canada L8G 5E4
Tel: 905.522.1155

West 5th Campus
100 West 5th Street
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Member, St. Joseph's Health System
Teaching Campus of the Faculty of Health Sciences, McMaster University
www.stjoes.ca

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