Consent to Disclose Personal Health Information

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The reason of the request is for:

□ Patient Care (non-standard of care) □ Patient Care (standard of care) □ Research
□ Medico-Legal □ Education □ Clinical Trial
□ Other: _____

I, _____, authorize the Laboratory Medicine Program
(Patient/Client)
Toronto General Hospital site of The University Health Network to disclose:
□ my personal health information consisting of:

_____

_____
(Describe the personal health information to be disclosed)

or

□ the personal health information of _____
** (Name of person for whom you are the substitute decision-maker)*
consisting of: _____

_____
(Describe the personal health information to be disclosed)

to: _____
(Name of the Healthcare provider/Institute)

Address: _____
City: _____ Province/State: _____ Postal Code/Zip Code: _____
Tel:_____ Fax: _____

By signing below I understand the purpose for and approve the disclosing of this personal health information to the Healthcare provider/Institute noted above.

My Name: _____ Address: _____
Home Tel.:_____ Work Tel.: _____
Signature: _____Date:_____

Witness Name: _____Address:_____
Home Tel.:_____ Work Tel.:_____
Signature: _____ Date: _____

***Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**