UHN Medical Solutions
A DIVISION OF ALTUM HEALTH

CLIENT INFORMATION:

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____
_____

CONTACT INFORMATION: _____

UHN – INTERNATIONAL PATIENT PROGRAM AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

You, the **UHN-International Client**, are being asked to provide your consent for UHN-International to **release** your health information to specified healthcare practitioners or parties; **or** provide your consent for UHN-International to **obtain** your health information from or communicate with specified healthcare practitioners or parties. Please review the following carefully before you provide consent.

1. This consent document must be signed by:
   a. the patient; or the parent or legal guardian of the patient if the patient is under 16 years of age and unmarried; or the proper legal representative/substitute decision maker of the patient; and
   b. a witness to the patient's/guardian's/representative's/substitute decision-maker's (signatory's) signature.
2. This consent may be withdrawn or amended in writing, by you, at any time prior to expiration which is 6 months.
3. This consent does not permit the release of health information in the client chart that was obtained from other healthcare providers. It only authorizes the release of clinical reports and records generated during the course of services provided by Altum Health
4. If the patient/signatory does not read or understand English, the consent form must be interpreted for the patient/signatory.
5. The person who acts as the interpreter must sign this form as a witness to affirm that this document was interpreted for the patient. Please indicate if the interpreter is related to the patient/signatory.

I _____ **have read and understand the above information and consent**
(Print Full Name) **for UHN-International to do the following:**

The records/health information I consent to be released are records and personal health information related to services provided by UHN-International. I understand that this health information will be released to the agencies or person(s) outlined below:

_____
Name Address/Phone Number

The records/health information I consent UHN-International authorized parties to obtain are:

❒Records and personal health information from a relative and/or friend

❒Records and personal health information from other health care professionals

❒ I authorize UHN-International to contact my assessing/treating practitioner and share health information pursuant to sections 24 (1) 9 and 24.1 (1) 2 of the Statutory Accident Benefit Schedule.

I understand that health information will be obtained from the following agencies or person(s) outlined below:

_____
Name Address/Phone Number

X_____ _____ _____
Signature of Patient **Signature of Witness** **Date**

If the person signing is not the patient, state relationship and authority to do so:

_____ _____ _____ _____
Signature Interpreter/Legal Rep **Relationship** **Name of Witness (Please Print)** **Date**