

**FOR UHN STAFF ONLY:**

- Request Type:
- Patient
  - Legal
  - Insurance
  - Circle of Care
  - Other

**AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION  
Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)**

This request for patient records is made with implied consent, solely for the purposes of providing healthcare or assisting in providing healthcare for the above-named patient. There is no information that the patient has expressly withheld or withdrawn their consent to this disclosure. (PHIPA section 18(3)(b))

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Last name Given name

Address: \_\_\_\_\_  
Street City Province Postal Code

Phone #: \_\_\_\_\_ Health Card #: \_\_\_\_\_ Site: TGH / PMH / TWH / TRI /All/ Other

To Release to: (Name and address of Person Receiving Information)

Self  Lawyer  Insurance  Care Provider  Other: \_\_\_\_\_

Name: \_\_\_\_\_  
Last Name Given Name

Address: \_\_\_\_\_  
Street City Province Postal Code

Contact #: \_\_\_\_\_  
Phone Fax

Personal health information to be disclosed: (Please select one)  Review only  Requesting copies

All records relating to treatment(s): \_\_\_\_\_

All Records (from very first hospital visit to today's date) \_\_\_\_\_

**Authorization:**  
 In accordance with PHIPA, authorization must be signed by the patient or the substitute decision maker. If the Person signing is not the patient, state relationship and authority to do so.

Print: Patient Name/Substitute Decision Maker Name \_\_\_\_\_ Print: Name of Witness \_\_\_\_\_

Signature and Relationship \_\_\_\_\_ Signature of Witness \_\_\_\_\_

Date (DD/MM/YYYY) \_\_\_\_\_ Date (DD/MM/YYYY) \_\_\_\_\_

Interpreter: I have done my best to translate this form from English to \_\_\_\_\_ and will not divulge any information.  
(Indicate language)

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

This authorization will be valid for a three month period as of the date of the signature unless specified otherwise.  
 Withdrawal of Consent: This authorization may be withdrawn at any time, except with respect to actions already taken before the consent was withdrawn. Processing time is dependent on the volume of information requested and is approximately 3 - 15 business days.

Princess Margaret - HRS  
 3 Basement, RM 202  
 610 University Ave  
 Toronto, ON M5G 2M9

Toronto Rehab - HRS  
 East Wing Basement, Rm. B-109  
 550 University Ave  
 Toronto, ON M5G 2A2

