Rural Roads Health Services

Alexandra Hospital Ingersoll
Tillsonburg District Memorial Hospital

Consent for Access or Disclosure of Personal Health Information

Date: _____ PIN #_____
(YYYY/MM/DD) for Hospital Use only

I Consent to allow Rural Roads Health Services to access/disclose the following Information: (if applicable specify dates of visits, hospitalization, treatment, or other information as required)

_____

_____

Pertaining to: Last Name Given Name Middle Name

Date of Birth_____ Telephone: _____
(YYYY / MM / DD)

Address:

_____

Person/Agency to Receive the Requested Information:

_____

_____

This Information will be used for ☐ Personal Use/Copy ☐ Legal Copy ☐ Ongoing Care

☐Other (please describe)

_____

PATIENT/SUBSTITUE DECISION MAKER CONSENTING TO ACCESS OR DISCLOSURE:

Printed Name: _____ Signature: _____

Relationship if other than patient**:* ***Address & Telephone # if different than patient

_____ _____

Office Use only - Verification of identity of individual requesting information:

Form of ID: ❑ Driver's License ❑ Passport ❑ Notarized letter/Lawyer's letter

❑ Other (specify) _____

ID validated by _____ _____

Printed name Signature

Please Note: This Authorization for Release of Information is valid for 6 months and pertains to the disclosure of information that is specific to treatment received on or before the date signed. It can be amended or withdrawn at any time by written notification to the hospital.