WOODSTOCK HOSPITAL
Woodstock, ON

REQUEST TO ACCESS PERSONAL HEALTH INFORMATION OR CONSENT TO THE DISCLOSURE OF PERSONAL HEALTH INFORMATION

☐ **I** _____ **REQUEST ACCESS TO THE FOLLOWING INFORMATION:**
(Patient or SDM (Substitute Decision Maker)

☐ **I** _____ **CONSENT TO THE DISCLOSURE OF THE FOLLOWING:**
(Patient or SDM (Substitute Decision Maker)

(specify dates of visits, contacts, hospitalization, treatment, or other information as required)

_____

_____

PERTAINING TO:

Patient / Client Name: _____
Last Name Given Name Middle Name

Date of Birth: _____
(mmm,dd,yyyy)

PIN Number: _____ Telephone Number: _____

Address: _____

FROM (Name of hospital): _____

TO (Recipient): _____

Address: _____ Telephone Number: _____

For the purpose of: _____

Patient/SDM (with legal signing authority) requesting access or consenting to the disclosure:

Printed Name: _____ Signature: _____

Relationship if other than patient: _____

Address and Telephone if different than patient (if patient is incapable or deceased): _____

_____

Date (mmm,dd,yyyy): _____

Office Use Only - Verification of identity of individual requesting access or consenting to the disclosure:

Form of ID: ☐ Driver's License ☐ Passport ☐ Notarized letter/Lawyer's letter
☐ Other (specify): _____

ID validated by: _____ _____
Printed Name Signature

PLEASE NOTE: This Request To Access or Consent for Disclosure form, is valid for 6 months and pertains to the information that is specific to treatment received on or before the date signed. It can be altered or withdrawn by the patient or SDM at any time by written notification to the hospital. Withdrawal of consent is not retroactive to information already disclosed.