



Riverside Health Care Facilities Inc.
 110 Victoria Avenue
 Fort Frances, Ontario P9A 2B7
 "Connecting Communities – Committed to Caring"

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION FORM

I, _____ hereby authorize Riverside Health Care Facilities Inc. to disclose the following personal information.

 (Description of personal health information to be disclosed and dates of contact/hospitalization)

to _____

 (Name and Address of person/agency requesting information)

from the records of _____
 _____ (Name of Patient) _____ (Birth date)

Mailing Address of Patient: _____

I understand that this personal health information is to be used **only** by the recipient for the purposes of:

- Delivery of direct patient care
- Research – Please specify type _____
- Fundraising – Name of Organization _____
- Administration of Health Care System
- Other: _____

I hereby waive any and all claims against Riverside Health Care Facilities Inc. in connection with the disclosure of this personal health information.

Witness: _____ Signed by: _____
 (Patient or Substitute Decision-Maker)

Date: _____

 (Relationship to Patient)