CONSENT TO RELEASE PERSONAL HEALTH INFORMATION FORM

CLIENT INFORMATION		
Last Name:	**First Name:**	**DOB (DD/MM/YY):**
No.:	**Street Name:**	**Suite No.:**
City:	**Province:**	**Postal Code:**
Contact #:	**Alternate #:**	

REASON FOR REQUEST TO RELEASE PERSONAL HEALTH INFORMATION

☐ Self ☐ Healthcare Provider ☐ Lawyer ☐ Insurance ☐ School/School board ☐ Other ______________________________________

I/we (Parent(s)/Substitute Decision Maker(s) Name: ____
request Grandview Kids to release personal health information of the above named client to (complete following section):

Name of Organization Information will be Released to:	**Name of Person Information will be Released to:**	
No.	**Street Name:**	**Suite No.:**
City:	**Province:**	**Postal Code:**
Contact Name:	**Contact #:**	
	Fax #:	

PERSONAL HEALTH INFORMATION AUTHORIZED FOR RELEASE

Approximate Date of visit(s) and Document(s) Required:

Reports Visit Dates Confirmation of Services Other (please specify below)

Additional Information:

Client /Parent/Substitute Decision Maker (Print)	**Signature**	**Date**

Notes:

1) A substitute decision-maker (SDM) is a person authorized under PHIPA to consent, on behalf of an individual, to the collection, use, or disclosure of personal health information about the individual.
2) Capable clients 16 years and older must sign consent on their own behalf.
3) Please complete the entire form; delays in processing your request may occur if submitted with missing information.
4) Please note that the release of information fulfillment period may take up to 30 days (we may request up to another 30 days if required).

Please Mail Requests to:

Clinical Information Services, Grandview Kids, 1461 Harwood Ave N,
Ajax, ON L1T 0R3

Fax #: (905) 728-2961 **Email:** roi@grandviewkids.ca