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:

☐ **Complete Copy of Client File** ☐ **Progress Notes** ☐ **Reports** ☐ **Consultation Notes**

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 entire form; delays in processing your request may occur if submitted with missing information.
4) We do have 30 days to respond to any request for records.

Please Forward Requests to:

Clinical Information Services, Grandview Kids, Oshawa-Main Site
600 Townline Road .S. Oshawa, ON.
Phone #: (905) 728-1673 ext. 2223 **Fax #:** (905) 728-2961