WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

R E L – I N F O

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

DATE OF REQUEST: _____

PART A: CONSENT OF PATIENT OR SUBSTITUTE DECISION MAKER **MRN Number** _____

I am the: ❒ Patient ❒ Substitute Decision Maker ❒ Legal Guardian

I, _____ hereby authorize Windsor Regional Hospital to disclose Personal Health Information record(s) of:

_____	_____	_____	_____
Last Name	First Name	Middle Initial(s)	Date of Birth (e.g. July 1, 1950)

_____	_____
Mailing Address (including City, Province, Postal Code)	Telephone Number

To: _____

Substitute Decision Maker has shown ❒ Copy of Will ❒ Power of Attorney Documentation ❒ Notarized Letter

(B) If you are a substitute decision-maker, your contact information:
Include copies of documentation that provide your authority as a substitute decision-maker.

_____	_____	_____	_____
Last Name	First Name	Middle Initial(s)	Date of Birth (e.g. July 1, 1950)

_____	_____
Mailing Address (including City, Province, Postal Code)	Telephone Number

I wish to obtain the following record (s):

❒ Verification of Birth Letter ❒ Patient Chart ❒ Diagnostic Imaging (i.e. X-ray, Ultrasound) MET Campus ❒ Visit Dates

Specific Visit: _____ **or** Visit(s) from: _____ to _____
(Enter date –e.g. July 1, 1950) (Enter dates –e.g. July 1, 1950)

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

❒ Personal Use ❒ Legal Proceedings ❒Insurance Claim(s) ❒ Medical Care ❒ Other_____
(Please specify)

❒ I hereby waive any and all claims against Windsor Regional Hospital in connection with the disclosure of this personal health information. I understand Windsor Regional Hospital will provide requested Personal Health Information to me in a view only format on a Computer Disc. _____.

❒ I agree to pay for all costs associated with processing this request to Windsor Regional Hospital, Health Record Department. _____.

Signature: _____ **Date:** _____

Relationship to patient (where applicable): _____

Identification Checked ❒ **Checked by:** _____

Witness Signature: _____ **Date:** _____

Witness Address: _____