Mount Sinai Hospital
Sinai Health System
Joseph & Wolf Lebovic Health Complex

Consent for Disclosure of Personal Health Information

Clearly Imprint Patient Identification

Health Records Services
600 University Avenue, Suite 460
Toronto, Ontario, Canada M5G 1X5
T: (416) 586-4800, Ext. 2651
F: (416) 586-3181
Web Site: www.mtsinai.on.ca

Form MS 704 A **TRIAL** (Rev 08.2017) Page 1 of 1

Check preferred format:
☐ Paper Copy
☐ USB Key ☐ CD **(Only applicable to visits after January 1st, 2014)**

Check Method of Delivery:
☐ Pick up ☐ Mail

Patient Information

Patient/Client Name _____ Date of Birth _____
LAST NAME FIRST NAME INITIAL (YYYY MM DD)

Address _____

City _____ Province _____ Postal Code _____

Residential Telephone # (_____) _____ Business Telephone # (_____) _____

Recipient

I authorize/request **Mount Sinai Hospital** to disclose patient/client personal health information to:

Name of Third Party/Health Care Institution/Health Care Provider _____

Address _____

City _____ Province _____ Postal Code _____

Telephone # (_____) _____ Fax # (_____) _____

Requested Records

Personal health information relating to: *(specify health information)* _____

_____

_____

Personal health information relating to the following treatment or admission. Specify dates, if possible

1. Admission date _____ (YYYY MM DD)
   Discharge date _____ (YYYY MM DD)

2. Admission date _____ (YYYY MM DD)
   Discharge date _____ (YYYY MM DD)

3. Admission date _____ (YYYY MM DD)
   Discharge date _____ (YYYY MM DD)

Reason for this request is: ☐ Further medical treatment ☐ Lawyer ☐ Insurance

☐ Estate settlements (a copy of the first and last page of the will or the Certificate of appointment is required)

☐ Other _____

I understand the purpose for disclosing this personal health information to the person noted above.

If the person signing is not the Patient, please state the relationship and authority to do so.

I acknowledge that the records on the USB or CD are not encrypted or password protected and I accept responsibility for protecting this information from unauthorized disclosure.

I acknowledge that records delivered by mail will be left at the address provided and will not require a signature. A courier service is available on request for an additional fee.

_____ SIGNATURE OF PATIENT or SUBSTITUTE DECISION MAKER

_____ SIGNATURE OF WITNESS

_____ PRINT NAME

_____ PRINT NAME

_____ DATE (YYYY MM DD)

_____ DATE (YYYY MM DD)

_____ RELATIONSHIP TO PATIENT/AUTHORITY
(i.e. Next of Kin or Power of Attorney, (copy of Power of Attorney for personal care required))

This authorization will be valid for a three (3) month period as of the date of signature unless specified otherwise. The authorization may be withdrawn in writing at any time.

MS704