HEALTH RECORDS DEPARTMENT

Phone: (519)749-6436 Fax: (519)749-6568 email: ReleaseofInfo@smgh.ca

AUTHORIZATION FOR DISCLOSURE OF PATIENT INFORMATION

I HEREBY AUTHORIZE ST. MARY'S GENERAL HOSPITAL, 911 Queen's Blvd, KITCHENER, Ontario TO RELEASE TO:

NAME: ____ **PHONE #:** ____________________

ADDRESS: ____ **FAX#:** ____________________

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TYPE OF INFORMATION REQUESTED: ☐ **Medical Records** ☐ **Medical Imaging (CD/FILMS)**

DATE PERIOD FOR MATERIAL REQUESTED:

____

NAME OF PATIENT:

____

(If name was different at time of treatment, please include both names, i.e. maiden name)

PATIENTS ADDRESS:

____

DATE OF BIRTH: ________________ **DAY TIME PHONE #:** ________________ **FAX#:** ________________

OHIP#: ________________________

____ ____________________

SIGNATURE OF PATIENT OR AUTHORIZED PERSON **DATE (YYYY/MM/DD)**

____

PRINT NAME AND RELATIONSHIP TO PATIENT IF AUTHORIZED PERSON SIGNING ON BEHALF

____ ____________________

SIGNATURE OF WITNESS **DATE (YYYY/MM/DD)**

____

WITNESS NAME (PRINT)

NOTE: AUTHORIZATION MUST BE DATED AND SIGNED OR IT WILL BE RETURNED.

1. This authorization must be dated and will remain valid for six months from the date of signing.
2. This authorization pertains only to information dated prior to the date it was signed.
3. This authorization must contain the original signature of the patient or one of the following authorized persons if the patient is incapable of consent:
   a) the parent or person who has lawful custody of the patient
   b) the legal representative if the patient is deceased or has been certified mentally incompetent.
4. This authorization must also contain the original signature of the person witnessing the patient's signature.

REQUIRED FEES

COPIES OF MEDICAL RECORDS: A non-refundable fee of $30.00 + HST for the first 20 pages with a $0.25 per page for subsequent pages.

MEDICAL IMAGING/CD FILMS: A non-refundable fee of $10 + HST per Medical Imaging CD.

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