# Consent for Release of Personal Health Information

## 1) Patient Information

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|---|---|
| **Last name:** | **First name:** |
| **Middle name:** | **Date of birth:** |
| **Mailing address:** | |
| **City:** | **Province:** |
| **Country:** | **Postal code:** |
| **Health card number:** | **Phone number:** |
| **Email address:** | |

## 2) Person or Agency to Receive the Information

The undersigned hereby authorizes St. Thomas-Elgin General Hospital (STEGH) to release personal health information to:

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| **Name of person or agency:** | |
| **Mailing address:** | |
| **City:** | **Province:** |
| **Country:** | **Postal code:** |
| **Phone number:** | **Email address:** |

## 3) Personal Health Information Authorized for Release

**Type of information for release:** (Examples include Discharge Summary, Emergency Room Report, Operative or Pathology Report, Admission Note, Radiology Report and Consultation Notes. If other, please specify.)

**Relevant dates:**

**How would you like this information to be received?** (Options include regular mail, in-office pick up or emailed via secure file transfer.)

**Print patient / substitute decision maker / power of attorney / executor's name:**

**Signature of consenting patient / substitute decision maker / power of attorney / executor:** (Please print to sign, as electronic signatures are not accepted.)

**Date consented:**

**If the person signing is not the patient, please provide St. Thomas-Elgin General Hospital (STEGH) with documentation of your authority to obtain this information.**

**NOTE:** Processing of this request is subject to administration fees. This Consent for Release form pertains to the disclosure of personal health information that is specific to treatment received on or before the date signed. It can be altered or withdrawn by the patient or alternate at any time by written notification to the hospital. Withdrawal of consent is not retroactive to information already released.

# How to Submit Your Request

You must submit **all** of the following for us to process your request:

1. This completed consent form signed by the patient (or other person with legal signing authority). If applicable a copy of the Power of Attorney for Health Care or Will must accompany the signed consent.
2. A copy of the patient's government-issued photo identification (or documentation of other signing authority).
3. An initial processing fee of $33.90.

The processing fee can be paid by **cheque** (payable to St. Thomas-Elgin General Hospital) or over the phone by **credit card** (519-631-2030 extension 2387). STEGH online payment portal (www.stegh.on.ca/patients-visitors/pay-a-bill), please use invoice # 12345 and forward copy of paid receipt to roi@stegh.on.ca.

All documents can be submitted by **email** (roi@stegh.on.ca), **fax** (519-637-3228) or **regular mail** (St. Thomas-Elgin General Hospital, Attn: Release of Information Department, 189 Elm St., St. Thomas, Ontario, Canada, N5R 5C4).

**To speak to a Release of Personal Health Information specialist, please call 519-631-2030, extension 2387.**

# For Hospital Use Only

| | |
|---|---|
| **Payment type:** ☐ Cheque ☐ Credit Card ☐ Other: | |
| **Amount received:** | **Date of intake:** |
| **Verification of identification:** ☐ Health card ☐ Driver's license ☐ Passport ☐ Other: | |
| **Request number:** | **Identification checked by:** |
| **Signature:** | |