HANOVER & DISTRICT HOSPITAL

90 - 7th Avenue,
Hanover, N4N 1N1
Phone 519-364-2340

DISCLOSURE OF PERSONAL HEALTH INFORMATION

MRN HH _____

I _____ hereby authorize Hanover & District Hospital to disclose the following personal health information:

_____

_____

(Description of personal health information to be disclosed and dates of contact/ Hanover & District Hospital)

to _____

_____

(name and address of person/agency requesting information)

from the records of _____
(Name of patient) (Birth date)

Mailing address of patient: _____

_____

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

_____

Date: _____

I hereby waive any and all claims against the Hanover and District Hospital in connection with the disclosure of this personal health information.

Witness: _____ Signed by _____
(Patient or substitute decision-maker)

Date: _____ _____
(Relationship to the patient)

For Institution only:
Processed by:

_____ _____ _____
Signature Name Date

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