CAMBRIDGE MEMORIAL HOSPITAL

For Internal Use Only
Pt. ID#_____.
Pt. Acct# _____.
Date _____.
Request# _____.

700 Coronation Blvd
Cambridge, ON N1R 3G2
P: (519) 621-2333 Ext. 1382
F: (519) 740-4658
Email: ReleaseofInfo@cmh.org

PATIENT AUTHORIZATION FOR THE COLLECTION/RELEASE OF PERSONAL HEALTH INFORMATION

Authorization must be signed by the patient or by the legally authorized representative in the case of incompetency or death.

I, _____hereby authorize

CAMBRIDGE MEMORIAL HOSPITAL to ☐ Release ☐ Collect

Records pertaining to the admission(s)/visit(s) from _____to _____,

Compiled at: _____,

From the health record of: _____,

Contact Phone# _____ HCN #/Photo ID_____.

Leave Message: ☐ Yes ☐ No

Request:

Requested by: (Specific Name, Unit, or Dept.) _____.

Requestor Agency Name & Department _____.

Address _____.

Phone # _____.

Email _____.

Purpose:

This Information will be used for the purpose of:

☐ Police related matter and/or Investigation

Consent

I understand the private and confidential nature of this information and agree that it will only be used for the stated purpose. I further absolve the information-releasing Hospital named above of any responsibility for carrying out this directive. This authorization will be valid for 90 days as of the date of signature, unless specified otherwise.

Signature _____ Date consent signed _____.

Consent Expiry _____ Relationship _____.

Witness name _____ Witness signature _____.