

**CONSENT FOR ACCESS OR DISCLOSURE OF PERSONAL INFORMATION  
and/or PERSONAL HEALTH INFORMATION**

DATE (YYYY/MM/DD): \_\_\_\_\_

PIN#: \_\_\_\_\_  
(for LHSC/SJHC office use)

**I CONSENT TO ALLOW:** (check ✓ one only)

- London Health Sciences Centre  St. Joseph's Health Care, London  
 Other health facility, practitioner or agency (specify): \_\_\_\_\_

**TO ACCESS/DISCLOSE THE FOLLOWING INFORMATION:** (If applicable, specify dates of visits, contacts, hospitalization, treatment, or other information required)

\_\_\_\_\_  
\_\_\_\_\_

**CONCERNING:**

Patient / Client Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last Name Given Name Middle Name (YYYY/MM/DD)

Address: \_\_\_\_\_ HC #: \_\_\_\_\_  
\_\_\_\_\_ Telephone #: \_\_\_\_\_

**Person / Agency to receive information:** \_\_\_\_\_

Address: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**I understand that this information is to be used by the Recipient for the purpose of:**

\_\_\_\_\_

**Patient/client/resident or person (with legal signing authority) consenting to access/disclosure:**

Printed Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship if other than patient/client/resident: \_\_\_\_\_ Address & Telephone # if different than  
(if patient/client/resident is incapable or deceased) patient/client: \_\_\_\_\_

\_\_\_\_\_

**Office Use only - Verification of identity of individual consenting to the access/disclosure:**

Form of ID:  Drivers License  Passport  Notarized letter/Lawyer's letter  
 Other (specify): \_\_\_\_\_

ID Checked by: \_\_\_\_\_  
Printed Name Signature

**PLEASE NOTE:** This Consent For Access or Disclosure pertains to the disclosure of 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 It can be altered or withdrawn by the patient or alternate at any time by written notification to the hospital.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.