

SECTION 6: CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

To be completed for all referrals (by Social Worker/Discharge Planner/Case Manager):

I agree that _____ may release my personal health information to make a referral.
(Name of facility disclosing information)

Organizations referred to:

<input type="checkbox"/> Baycrest	<input type="checkbox"/> Markham Stouffville Hospital	<input type="checkbox"/> Toronto East General Hospital	<input type="checkbox"/> William Osler Health Centre
<input type="checkbox"/> Bridgepoint Health	<input type="checkbox"/> Providence Healthcare	<input type="checkbox"/> Toronto Grace Health Centre	<input type="checkbox"/> York Central Hospital
<input type="checkbox"/> Credit Valley Hospital	<input type="checkbox"/> Rouge Valley Health System	<input type="checkbox"/> Toronto Rehab/UHN	<input type="checkbox"/> Other
<input type="checkbox"/> Halton Healthcare Services	<input type="checkbox"/> Southlake Regional Health Centre	<input type="checkbox"/> Trillium Health Centre	(specify): _____
<input type="checkbox"/> Lakeridge Health	<input type="checkbox"/> St. John's Rehab Hospital	<input type="checkbox"/> West Park Healthcare Centre	

To be completed for all referrals:

Print Name of Patient: _____

Signature of Patient/Substitute: _____ Date:(YYYY/MM/DD) _____

Name of Substitute: _____
(print name)

Relationship to patient, if signed by Substitute: _____

- Yes, an interpreter was used when consent was obtained.
- No interpreter was required.