



# AUTHORIZATION FOR RELEASE AND FAX TRANSMISSION Of Patient Record and Referral or Preadmission Form

## FAX TRANSMISSION

**Fax From:** Name: \_\_\_\_\_ Phone/Pager: \_\_\_\_\_  
Organization: \_\_\_\_\_ Unit: \_\_\_\_\_

**Fax To:**  Baycrest 416-785-2317  St. John's 416-226-5406  
 Bridgepoint 416-461-5499  Toronto Rehab 416-537-3752  
 Providence 416-285-3759  West Park 416-243-8397  
 Other (specify) \_\_\_\_\_  Other (specify) \_\_\_\_\_

**Number of pages:** \_\_\_\_\_ (including fax cover and consent page)

## PATIENT CONSENT

### A) Information Release

I \_\_\_\_\_ hereby authorize \_\_\_\_\_  
*Name of patient or substitute decision maker* *Name of organization*

to release the following information on \_\_\_\_\_ from the patient  
*Patient's Name*

record, referral form or preadmission form for the purposes of determining eligibility for services to the organizations identified in the FAX TO box above.

Please check to indicate your consent to part A): Yes \_\_\_\_\_ No \_\_\_\_\_

### B) Use of Information From the Referral Forms for Research/System Improvement

I also understand and consent that information from the referral form, with the exception of any information that would identify the patient (i.e., name, address, health card number, postal codes, names of agents or substitute decision makers, etc.), may be used to produce reports and further research and system improvements.

Please check to indicate your consent to part B): Yes \_\_\_\_\_ No \_\_\_\_\_

### Individual providing consent:

Name of individual providing consent: \_\_\_\_\_

Relationship if not patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date of signature: Y/ \_\_\_\_\_ M/ \_\_\_\_\_ D/ \_\_\_\_\_

Date of expiration of authorization: Y/ \_\_\_\_\_ M/ \_\_\_\_\_ D/ \_\_\_\_\_