Alzheimer Society
PEEL

# Consent for Release of Personal Health Information

## Patient Information

| | | | |
|---|---|---|---|
| Last Name: | | First Name: | Initial: |
| No.: | Street Name: | | Apartment No.: |
| City: | | Province/State: | Country: |
| Postal Code/Zip: | | Date of Birth: | Gender: |
| Contact Number - Area Code & Number: | Extension: | Alternate Number - Area Code & Number: | Extension: |

## Reason For Request and Release of Information

❑ Self ❑ Health Care Provider ❑ Lawyer ❑ Insurance ❑ WSIB ❑ Other:

**The undersigned hereby requests Alzheimer Society Peel to release/obtain my personal health information to**:

Name of Health Care Provider / Third Party:

| | | | |
|---|---|---|---|
| No.: | Street Name: | | Apartment No.: |
| City: | | Province/State: | |
| Country: | | Postal Code/Zip: | |
| Contact Number: | Area Code & Number: | Extension: | Fax #: Area Code & Number: |

## Personal Health Information Authorized for Release

| Document(s) Required: | Date of Visit(s): |
|---|---|
| | |
| | |
| | |
| | |

***Substitute Decision Maker (SDM) must provide the hospital with authorizing documentation.**

Date: _____

*Day / Month / Year*

Patient/SDM: *

_____

*(Signature)* *(Please print name)*

Witness: _____ _____

*(Signature)* *(Please print name)*

| For Internal Use only | |
|---|---|
| Hospital Fee: | ACORN File Record # |

Personal information contained in this form is collected in accordance with the *Freedom of Information and Protection of Privacy Act* for the purpose of consenting to disclosure of personal health information.
Questions about this collection can be directed to the Chief Privacy Officers, (905) 278-3667 ext 204.

**Please forward to:** Alzheimer Society Peel 60 Briarwood Avenue Mississauga, ON L5C 3R9 - Phone: (905) 278-3667 ext. 204 – Fax: (905) 278-3674

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