Lake of the Woods District Hospital

Consent to Disclose Health Information

Patient Information:

Last Name: _____ First Name: _____

Date of Birth (dd/mm/yyy): _____ Phone Number: _____

Mailing Address: _____

Records Requested:

Please provide details of the records you require including the date, name of healthcare provider, service provided, etc.

_____

_____

_____

Recipient Information (name, address, phone number)**:**

_____

_____

Authorization:

I, _____, have the legal authority to make this request in my capacity as:

☐ the patient

☐ the patient's substitute decision maker (please include documentation proving authority)

☐ the Estate Trustee/Executor for a deceased patient (please include documentation proving authority)

☐ Other (please explain): _____

Signature: _____ Date (dd/mm/yyyy): _____

I hereby authorize Lake of the Woods District Hospital (LWDH) to disclose the personal health information/records of the patient listed above to the recipient listed above. I understand the purposes for which the recipient will handle this information. I hereby waive any and all claims against LWDH in connection with the disclosure of this information.

Staff Only:

□ Verbal consent obtained (Print name of LWDH Staff): _____

Signature: _____ Date (dd/mm/yyyy): _____

To be completed by LWDH staff member processing request:

Date Request Received (dd/mm/yyyy): _____

Date Request Processed (dd/mm/yyyy): _____

Guidelines:

1. Patient or substitute decision maker (SDM) must complete this form or submit a letter containing all required information. If the request is authorized, the LWDH employee will attach copies to the request.
2. LWDH Employee must date the form on receipt.
3. If the request is approved, health records staff will document the date processed on this form as well as in the Release of Information Meditech log.
4. Authorization form will be kept in the patient chart.