



**Riverside Health Care Facilities Inc.**  
 110 Victoria Avenue  
 Fort Frances, Ontario P9A 2B7  
 "Connecting Communities – Committed to Caring"

## CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION FORM

I, \_\_\_\_\_ hereby authorize Riverside Health Care Facilities Inc. to disclose the following personal information.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 (Description of personal health information to be disclosed and dates of contact/hospitalization)

to \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 (Name and Address of person/agency requesting information)

from the records of \_\_\_\_\_  
 \_\_\_\_\_ (Name of Patient) \_\_\_\_\_ (Birth date)

Mailing Address of Patient: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

I understand that this personal health information is to be used **only** by the recipient for the purposes of:

- Delivery of direct patient care
- Research – Please specify type \_\_\_\_\_
- Fundraising – Name of Organization \_\_\_\_\_
- Administration of Health Care System
- Other: \_\_\_\_\_

I hereby waive any and all claims against Riverside Health Care Facilities Inc. in connection with the disclosure of this personal health information.

Witness: \_\_\_\_\_ Signed by: \_\_\_\_\_  
 (Patient or Substitute Decision-Maker)

Date: \_\_\_\_\_  
 \_\_\_\_\_  
 (Relationship to Patient)