MARKHAM STOUFFVILLE HOSPITAL CORPORATION

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CONSENT TO RELEASE PERSONAL HEALTH INFORMATION
(From a Diagnostic System Record)

Patient Name:	Date of Birth (DD/MM/YYYY)	Patient I.D.#
Address:		**Health Card #**
Phone # (Best Daytime):	Alternate #:	

I hereby authorize the **Diagnostic System** of Markham Stouffville Hospital or Cottage Hospital Uxbridge to release to:

Doctor's Name: _____

Address: _____

any diagnostic images contained in the record of my visit on _____
Date

☐ Emergency visit on: _____
Date

Specific to: _____

_____

In addition to above, I waive any and all claims against Markham Stouffville Hospital in connection with disclosure or use of this personal information once released.

_____ _____
Patient/Substitute Decision Maker Signature **Witness Signature**

_____ _____
Print Name **Print Name**

_____ _____
Date **Date**

Note:
1. This form must have an original signature of the patient/legal representative and it must be witnessed and dated. witnessed and dated.
2. This authorization must be dated within three (3) months of submission.
3. This authorization only pertains to information dated prior to the date it was signed.

OFFICE USE

Specify CD, Film, Video and description of study _____

☐ **CD** ☐ **Film** ☐ **Video** ☐ **Other** (specify) _____