CHATHAM-KENT
Health Alliance

Campus
80 Grand Ave W
Chatham, On
325 Margaret Ave
Wallaceburg, ON

Mailing Address:
P.O. Box 2030 Chatham, ON, N7M 5L9

Consent to Disclose Personal Health Information

I _____ hereby authorize the Chatham-Kent Health Alliance –

(please tick appropriate campus)
- ☐ Grand Ave Campus
- ☐ Sydenham Campus
- ☐ Mental Health Clinic

to [disclose / obtain] the following personal health information:
(please circle)

_____
(Description of personal health information)

[To] / From]: **RECORDS DEPOSITION SERVICE, INC.** PO BOX 5054 SOUTHFIELD, MI 48086-5054 P: 248.357.3330 F: 248.357.3337
(Please circle)
(Name and address of person/agency requesting information)

from the records of _____ _____
(Print Name of Patient) (Date of Birth – Month/Day/Year)

during the period of: _____ to _____
(Month/Day/Year) (Month/Day/Year)

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

Purposes of: **DISCOVERY BEFORE TRIAL**

_____

I hereby waive any and all claims against the Chatham-Kent Health Alliance in connection with the disclosure of this personal health information.

_____ _____
(Signature of Person giving Authorization) (Signature of Witness)

_____ _____
(Relationship/Title if not signed by Patient) (Print Name of Witness)

Dated: _____

1. This form will be used in conjunction with all requests for information from the hospital records.
2. "Patient" includes current inpatient, former patient, or outpatient.
3. The form may be signed by:

(a) patient
(b) executor of the estate or legal representative of a patient who is deceased
(c) custodial parent or legal guardian of a patient who is unmarried and under the age of sixteen (16) years
(d) a person lawfully authorized to make treatment decisions on behalf of an incapable person

4. Where consent is signed by either (b) or (c) above, the relationship to the patient must be stated and verification of this relationship may be required.
5. Authorization is valid for six (6) months from the date of signing.
6. A copy of this consent will be sent to agencies, companies, etc. who request patient information, for an appropriate signature.
7. This form will be obtained when the Occupational Health Nurse requires Authorization to obtain or release information from an employee's health record.