HALIBURTON HIGHLANDS HEALTH SERVICES
Leaders in Innovative Rural Health Care

Haliburton Highlands Health Services
CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I, _____ hereby authorize ***Haliburton Highlands Health Services***
Name and Address of person/agency releasing the information

to disclose the following personal health information:

_____

_____

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

to _____

_____
(Name and address of person/agency requesting the information)

from the records of _____ _____
(Name of Patient) (Date of Birth dd/mm/yy)

_____
(Address of Patient)

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

_____

_____

I hereby waive any and all claims against Haliburton Highlands Health Services in connection with the disclosure of this personal health information.

Signed By: _____ Witness: _____
(Patient or Substitute Decision Maker)

_____ Date: _____
(Relationship to the Patient) (day/month/year)