



# University Health Network

Toronto General Hospital Toronto Western Hospital Princess Margaret Hospital

## AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORD INFORMATION

Patient's name: \_\_\_\_\_  
Last Name Given name Middle Initial MRN Date of Birth

Address: \_\_\_\_\_  
Street City Province Telephone #:

The undersigned hereby authorizes/requests the \_\_\_\_\_  
Health Care or Health Services Provider

To provide: \_\_\_\_\_  
Name of Third Party

Address: \_\_\_\_\_  
Street City Province Postal Code

With access to/or photocopies from (circle which) my medical records. The reason for this request is: \_\_\_\_\_

### The records I authorize to be accessed or photocopied are as follows:

- All records
- For review only
- Only records relating to the following treatment or admission:

Type of Treatment: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_

Expiration Date: (6 months or as stated) \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient Signature of Witness Date

### IF THE PERSON SIGNING IS NOT THE PATIENT, STATE RELATIONSHIP AND AUTHORITY TO DO SO.

\_\_\_\_\_  
Signature of Legal Representative Relationship Name of Witness (Please Print) Date

1. This authorization may be rescinded or amended in writing at any time prior to the expiration date except where action has been taken in reliance on the authorization.
2. This authorization must contain the original signature of:
  - a) The patient, or the parent or legal guardian if the patient is under 16 years of age and unmarried; or the legal representative if the patient is deceased or has been certified mentally incompetent, and
  - b) The witness to the patient's signature.
3. Requests for release of information must be dated after treatment dates.
4. If the patient does not read or understand English, the authorization form must be interpreted for the patient. The person who acts as the interpreter **must** sign the form as a witness to confirm that this has been done. Please indicate if the interpreter is related to the patient.

\_\_\_\_\_  
Signature of Interpreter Name of Interpreter/Relationship to Patient if Any (Please Print) Date

