

Authorization to Disclose Personal Health Information Form

under the Personal Health Information Protection Act, 2004 (PHIPA)

Authorization to Disclose Personal Health Information:

Resident

Legal Guardian (please provide documentation to satisfy the Health information Custodian that you are an authorized Legal Guardian)

Authorization being given to:

United Counties of Prescott and Russell Prescott and Russell Residence 1020 Cartier Boulevard, Hawkesbury ON K6A 1W7 PJuillet@prescott-russell.on.ca

Your Information:				
Mr. Mrs. Ms.	Miss	Last Name:		
First Name:		Middle Name:	Middle Name:	
Address: (Street/Apt. No./P.		C: /T		
Province:		Postal Code:		
Telephone Number (Day):		Telephone Number (evening):	Telephone Number (evening):	
Legal Guardian Information (if applicable):				
Indicate the Resident's Name	e:			
Mr. Mrs. Ms.	Miss	Last Name:		
First Name:		Middle Name:		
Address: (Street/Apt. No./P.	O. Box/R.R. No.):	C' /T		
Province:		Postal Code:		
Telephone Number (Day):		Telephone Number (evening):		
Authorization: I, hereby authorize the Prescott and Russell Residence to disclose the following				
personal information (please provide a specific description of the personal information to be disclosed):				
To the following Individual or Organization:				
Preferred method of access to records:	Examine Original Receive Copy	Signature:	Date:	

Questions can be addressed to: PJuillet@prescott-russell.on.ca

The personal health information contained on this form is collected pursuant to the *Personal Health Information Protection Act*, 2004 (the "Act") and will be used for the purpose of responding to your request for access pursuant to section 54 of the Act. Questions about this collection should be directed to the privacy Contact Person at the Health Information Custodian where the request for access is made.