London Health Sciences Centre

Children's Hospital
London Health Sciences Centre

Consent for Release of Personal Health Information

1) Patient Information

Last name:	**First name:**
Middle name:	**Date of birth:**
Mailing address:	
City:	**Province:**
Country:	**Postal code:**
Health card number:	**Phone number:**
Email address:	

2) Person or Agency to Receive the Information

The undersigned hereby authorizes London Health Sciences Centre (LHSC) to release personal health information to:

Name of person or agency:	
Mailing address:	
City:	**Province:**
Country:	**Postal code:**
Phone number:	**Email address:**

3) Personal Health Information Authorized for Release

Type of information for release: (Examples include Discharge Summary, Emergency Room Report, Operative or Pathology Report, Admission Note, Radiology Report and Consultation Notes. If other, please specify.)

Relevant dates:

How would you like this information to be received? (Options include regular mail, in-office pick up or emailed via secure file transfer.)

Print patient / substitute decision maker / power of attorney / executor's name:

Signature of consenting patient / substitute decision maker / power of attorney / executor: (Please print to sign, as electronic signatures are not accepted.)

Date consented:

If the person signing is not the patient, please provide London Health Sciences Centre (LHSC) with documentation of your authority to obtain this information.

NOTE: Processing of this request is subject to administration fees. This Consent for Release form pertains to the disclosure of personal health information that is specific to treatment received on or before the date signed. It can be altered or withdrawn by the patient or alternate at any time by written notification to the hospital. Withdrawal of consent is not retroactive to information already released.

How to Submit Your Request

You must submit **all** of the following for us to process your request:

1. This completed consent form signed by the patient (or other person with legal signing authority).
2. A copy of the patient's government-issued photo identification (or documentation of other signing authority).
3. An initial processing fee of $33.90.

The processing fee can be paid by **cheque** (payable to London Health Sciences Centre) or over the phone by **credit card** (519-685-8500 extension 52865).

All documents can be submitted by **email** (roi_lhsc@lhsc.on.ca), **fax** (519-685-8271) or **regular mail** (London Health Sciences Centre, Attn: Health Information Management department, 800 Commissioners Road East, Room C1-700, Post Office Box 5010, Station B., London, Ontario, Canada, N6A 5W9).

To speak to a Release of Personal Health Information specialist, please call 519-685-8500, extension 52865.

For Hospital Use Only

Payment type: ☐ Cheque ☐ Credit Card ☐ Other:	
Amount received:	**Date of intake:**
Verification of identification: ☐ Health card ☐ Driver's license ☐ Passport ☐ Other:	
Request number:	**Identification checked by:**
Signature:	