HALIBURTON HIGHLANDS HEALTH SERVICES
Working Together for the Health of the Highlands

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

I, _____, hereby authorize Haliburton Highlands Health Services
(Name of Person requesting information) (Name and Address of person/agency releasing the information)

To disclose the following personal health information: (Provide description of personal health information to be disclosed and dates of contact/hospitalization)

_____

_____

_____

To: (Provide name, address, and contact information of person/agency requesting the information)

_____

_____

_____

From the records of: _____ Date of Birth:_____
(Name of Patient) (D.O.B. dd/mm/yy)

Patient's Address_____

_____

(Postal Code)

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.

Print Name:	Witness Name:
Signature:	Witness Signature:
Date:	Date: