I, ____hereby authorize the Brant Community Healthcare system to disclose the following personal health information
(description of personal health information to be disclosed and date of contact /hospitalization)

____

____

____

____

to____

(name and address of person/agency requesting information)______________________________

____

____

____

from the records of ____
(name of patient) (date of birth)

Mailing address of Patient:____

____

____

____

I understand that this personal health information is to be used by the recipient for the purposes of: ____

____

Date: __________________________________

I hereby waive any and all claims against the Brant Community Health Care System in connection with the disclosure of this personal health information.

***Witness:* ______________________ *Signed by:* __________________________**
(Patient or substitute decision maker)

***Date:* ________________________ __________________________**
(Relationship to the Patient)

Please mail completed form back to <u>Release of Information</u> at the
Brantford General Hospital , 200 Terrace Hill Street
Brantford, Ontario
N3R 1G9

We cannot accept a faxed or e-mailed version of this form once completed.