CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Patient Name: ____ Birthdate: _______________ MR: ________

Street Address: _____________________________________ City: _________________ Province/State: _________
Zip: _____________

Dates of Treatment to Release:
Phone: ____________________________ SIN/SS #: ______ -- ____ -- ______ ❐ All ❐Specific Dates: ___________

Name/Organization: ____ Phone: ___________________________

Street Address: _____________________________________ City: _________________ Province/ State: _________
Zip: _____________

I AUTHORIZE GreeneStone MUskoka TO RELEASE TO ❐ AND RECEIVE FROM ❐
THE ABOVE PERSON/AGENCY THE FOLLOWING INFORMATION: (Check (Y) yes or Check (N) no)

__Y __N Admission Face Sheet
__Y __N History and Physical Exam
__Y __N Family Assessment
__Y __N Financial Information
__Y __N Treatment Update / Status – Verbal
__Y __N Treatment Update / Status – Written
__Y __N Treatment Plan and Reviews
__Y __N X-ray Reports
__Y __N Psychological Evaluation
__Y __N Assessment Report
__Y __N Progress Notes
__Y __N Nursing Assessment
__Y __N Medication List
__ Y __N Consent Forms
__Y __N Continuing Care Plan
__Y __N Laboratory Reports
__Y __N Drug Screens
__Y __N Physician Orders
__Y __N Biopsychosocial Questionnaire
__Y __N Psychiatric Consult/Evaluation
__Y __N Discharge Summary
__Y __N Correspondence (Specify): ____
__Y __N Other: (Specify): ____

FOR THE PURPOSE OF: ____

In addition to verbal and written reports I also agree this information may be released/exchanged: ____ Electronic
____ Fax

Medical records frequently contain confidential remarks furnished by the patient, patient's family and staff. If, in the judgment of the medical staff, disclosure of such information will be harmful to the patient, release of such information will be withheld.

I understand that information received or medical records prepared after this release form is completed, regarding my condition and the services I have received in the course of my diagnosis and treatment, may be subject to release to authorized parties in compliance with federal and state law and the terms of this form. **I understand that the records released may contain alcohol and drug treatment, AIDS/HIV or psychiatric/psychological/psychosexual information. I understand this communication will reveal my presence as a patient in a treatment facility.**

This release demonstrates compliance with the 2004 Ontario Personal Health Information Privacy Act (PHIPA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), and all federal regulations and interpretive guidelines promulgated thereunder. **The recipient of this information may not disclose this information unless another authorization is obtained from me or unless such disclosure is required or permitted by law)**. I understand once the requested information is disclosed, the PHIPA Privacy Regulations may no longer protect it should the recipient re-disclose it.

This consent for information is given freely, voluntarily and without coercion. I understand that I may revoke this consent to release information in writing at any time, except for information that has already been released under this valid consent. In any event, upon fulfillment of the above-stated purpose, this consent will automatically expire one year from the date signed. I further understand that GreeneStone Muskoka reserves the right to notify the above-named person, corporation or agency of my revocation in the event that I revoke this consent to release information.

____ ________________________
PATIENT SIGNATURE DATE

____ ________________________

WITNESS SIGNATURE DATE