Holland Bloorview
Kids Rehabilitation Hospital

Client Name: _____
Health Record No. _____
Date of Birth: _____

CONSENT TO COLLECT / DISCLOSE PERSONAL HEALTH INFORMATION

I, _____ , authorize Holland Bloorview Kids Rehabilitation Hospital to
Print Name in Full

☐ **collect** the following information: _____
Specific Description of Information

from:

_____ _____
Name of Organization *Address*

_____ _____
Name of Organization *Address*

AND/OR (circle one)

☐ **disclose** the following information: _____
Specific Description of Information

to:

_____ _____
Name *Address*

_____ _____
Name *Address*

From the records of:

_____ _____
Full Name of Client *Address of Client*

I understand that this personal health information is to be used **only** by the recipient for the purpose of:

_____
State the Reason why Information is Needed

Please note that disclosed personal health information may contain information related to other family members.

This authorization may be terminated or changed at any time by the undersigned through a written request to Health Information Management department, Holland Bloorview Kids Rehabilitation Hospital.

I hereby waive any and all claims against Holland Bloorview Kids Rehabilitation Hospital in connection with the disclosure of this personal information.

_____ _____ _____
Date *Signature of Client/Person Legally Authorized to Consent* *Relationship*

_____
Signature of Witness (Age 18 or over)

* C O N D I S C L O S *