Homewood Health | Santé

Consent to Disclosure of Personal Information to Others

☐ For Homewood Health Inc. **Out-patient counselling, treatment, disability management and occupational health**: Records Management, CIM-DS Clinical Information Management – Data Services, **Homewood Health Inc.** 150 Delhi Street, Guelph, Ontario N1E 6K9 Tele: (800) 265-8310, ext. 43113, Fax: (800) 427-9295 Email: requestforrecords@homewoodhealth.com	☐ For Homewood Health Centre **In-patient** Programs: Correspondence, CIM Clinical Information Management **Homewood Health Centre** 150 Delhi Street, Guelph, Ontario N1E 6K9 Tele: (519) 824-1010, ext. 32511, Fax: (519) 767-3552 Toll Free: (800) 265-8310, ext. 32511 Email: him@homewoodhealth.com

Print Last Name of Client/Patient | *Print First Name of Client/Patient* | YYYY MM DD *Client/Patient's Date of Birth*

Client/Patient Current Address & Telephone Number *(*or Substitute Decision Maker as indicated below)*:

Full Mailing Address (Unit Number, PO Box, Street Number, Street Name, City, Province, Postal Code)

Primary Telephone Number | *Secondary Telephone Number(s)*

Substitute Decision Makers (SDM):** if you are requesting information on behalf of a Client/Patient including a minor child, provide the client name but provide ***your current address and contact information above. The Client/Patient must be incapable of making decisions regarding the disclosure of personal information. Documentation to support your authority in the role of SDM is required.
SDM Name (If Applicable):

☐ Confirmation of Attendance Letter (dates and **category** of issue addressed)

- ***Do Not Include*** issue addressed category in Letter ☐

☐ Copies of clinical record(s) **Fees Apply ($30 first 20 pages, $0.25 per page thereafter)*

Describe the information being requested including date range and indicate the applicable treatment and/or service, if known:

I hereby authorize Homewood Health to Disclose Personal Information to:

Full Name of Individual and Organization to Receive Information

Street Address, City, Province, Postal Code

Telephone Number | *Alternate Telephone Number* | *Fax Number*

Email/Fax: I authorize the encrypted email/unencrypted fax transmission of my personal information to the above recipient. I understand the risk of accidental disclosure, and the possibility that the information may be intercepted by people other than the intended recipient.
Email/Fax: Yes ☐ No ☐ Email Address/Fax Number:

Consent exceeding 6 months from the signature date may require verification and/or resubmission

Signature of Witness (required) | ***Signature of Client/Patient/SDM (required)***

YYYY MM DD
Date (yyyy mm dd) | *SDM Relationship If Other Than Client/Patient*

Homewood's Statement of Information Practices is available at https://homewoodhealth.com/corporate/privacy-and-records