



Consent to Disclose Personal Health Information

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The reason of the request is for:

- Patient Care (non-standard of care)
- Patient Care (standard of care)
- Research
- Medico-Legal
- Education
- Clinical Trial
- Other: _____

I, _____, authorize the Laboratory Medicine Program
(Patient/Client)

Toronto General Hospital site of The University Health Network to disclose:

- my personal health information consisting of:

(Describe the personal health information to be disclosed)

or

- the personal health information of _____
**(Name of person for whom you are the substitute decision-maker)*
consisting of: _____

(Describe the personal health information to be disclosed)

to: _____
(Name of the Healthcare provider/Institute)

Address: _____

City: _____ **Province/State:** _____ **Postal Code/Zip Code:** _____

Tel: _____ **Fax:** _____

By signing below I understand the purpose for and approve the disclosing of this personal health information to the Healthcare provider/Institute noted above.

My Name: _____ **Address:** _____

Home Tel.: _____ **Work Tel.:** _____

Signature: _____ **Date:** _____

Witness Name: _____ **Address:** _____

Home Tel.: _____ **Work Tel.:** _____

Signature: _____ **Date:** _____

***Please note: A substitute decision-maker is a person authorized under PHIPA to consent, on behalf of an individual, to disclose personal health information about the individual.**