WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

Patient Information / Sticker
Name: _____
DOB (mm/dd/yyyy): _____
MRN: _____

PATIENT AUTHORIZATION FOR COLLECTION & RELEASE OF PERSONAL HEALTH INFORMATION

RESET PRINT

Metropolitan Campus
1995 Lens Avenue
Windsor, ON N8W 1L9

Ouellette Campus
1030 Ouellette Avenue
Windsor, ON N9A 1E1

Tel: 519-254-5577, ext. 52238
Website: www.wrh.on.ca

Authorization must be signed by the patient or by the legally authorized representative in the case of incompetency or death.

I, _____, hereby authorize
(Name of Patient / Substitute Decision Maker)

WINDSOR REGIONAL HOSPITAL to ☐ **Release** ☐ **Collect**

records pertaining to the admission(s) / visit(s) from _____ to _____
(mm/dd/yyyy) *(mm/dd/yyyy)*

compiled at: _____
(Institution)

from the Health Record of: _____ _____
(Patient Name) *(Date of Birth, mm/dd/yyyy)*

Contact Phone #: _____ Health Card # /Photo ID: _____

Leave Message: ☐ Yes ☐ No

REQUEST:

Requested by (Specific Name, Unit, or Dept.): _____

Requestor Agency Name & Department: _____
(e.g. Insurance Company, Lawyer, Physician Office)

Address: _____

PURPOSE:

This information will be used for the purpose of:

- ☐ Further Medical Treatment
- ☐ Estate Settlement
- ☐ Mental Health Assessment and/or Treatment
- ☐ Other: _____
- ☐ Insurance Claim
- ☐ Litigation
- ☐ Contact Information
- ☐ Physician Reference
- ☐ Research Review
- ☐ Clinical Photos/Education

CONSENT:

- ☐ I understand the private and confidential nature of this information and agree that it will be used only for the stated purpose(s). I further absolve the information – releasing the Hospital named above of any responsibility for carrying out this directive. This authorization will be valid for 90 days as of the date of signature, unless specified otherwise.
- ☐ I understand that I may withdraw my consent at any time by informing my Windsor Regional Hospital contact.
- ☐ Cancer Centre Patients: - I understand that my chart may be reviewed for research and contact information purposes.
  - As part of my patient record, I agree that clinical photographs may be taken. These photos may be used for education also as long as I am not identifiable in any such photos.

Date of Consent: _____ **Signature**: _____
(mm/dd/yyyy)

Consent Expiry Date: _____ _____
(mm/dd/yyyy) ***(Relationship if other than patient)***

Email Address: _____ **Consent to Release via Email (Initial if yes):** _____

Witness' Signature: _____ **Witness' Name** - *Print*: _____

If unable to submit online, please email to WRHROIClerks@wrh.on.ca or fax to 519-254-5572 & include a copy of photo ID.