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 Data Resources, 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)