WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

PATIENT AUTHORIZATION FOR COLLECTION & RELEASE OF PERSONAL HEALTH INFORMATION

PATIENT LABEL

Metropolitan Campus
1995 Lens Avenue
Windsor, ON N8W 1L9

Tel: 519-254-5577

Ouellette Campus
1030 Ouellette Avenue
Windsor, ON N9A 1E1

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 Number / 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
- ☐ Litigation
- ☐ Physician Reference
- ☐ Other:_____
- ☐ Insurance Claim
- ☐ Estate Settlement
- ☐ Mental Health Assessment and/or Treatment

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.

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

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

Email Address:_____

Witness:_____ Witness Name:_____
(Signature) *(Print Name)*

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