WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

CONSENT TO RELEASE PERSONAL HEALTH INFORMATION - TELEMEDICINE

I ____ hereby authorize
(Print Name of Patient or Substitute Decision-Maker)

Windsor Regional Hospital to disclose the following personal health information:

____
(Description of personal health information to be disclosed)

to ____
(Name and address of person/agency requesting personal health information)

from the records of ______________________________ ______________________
(Name of patient) (Date of birth)

____
(Address of patient)

concerning the treatment on or around ______________________________________
(Date(s) of contact/hospitalization)

I understand that this personal health information is to be used **only** by the recipient for the purpose of:

____

____

I hereby waive any and all claims against Windsor Regional Hospital in connection with the disclosure of this personal health information.
Signed by: ____

____
(Relationship if signed by other than patient)

______________________ ____
(Date) (Signature of Witness)

Windsor Regional Hospital - Campus (Metropolitan or Tayfour)

____
(Address of Witness)

<u>Note:</u>

1. This consent must contain the **<u>ORIGINAL</u>** signature of:
   a) The patient; or the substitute decision-maker (person with legal authority to consent for the patient);
   b) The witness to the patient's or substitute decision-maker's signature.
2. This consent may be rescinded or amended in writing at any time, except where action has been taken in reliance on the consent.