



I, _____ hereby authorize the Brant Community Healthcare system to disclose the following personal health information
(description of personal health information to be disclosed and date of contact /hospitalization)

to _____

(name and address of person/agency requesting information) _____

Tel: _____

from the records of _____ (name of patient) _____ (date of birth)

Mailing address of Patient: _____

Tel: _____

I understand that this personal health information is to be used by the recipient for the purposes of: _____

Date: _____

I hereby waive any and all claims against the Brant Community Health Care System in connection with the disclosure of this personal health information.

Witness: _____

Signed by: _____

(Patient or substitute decision maker)

Date: _____

(Relationship to the Patient)

Please mail completed form back to Release of Information at the
Brantford General Hospital, 200 Terrace Hill Street
Brantford, Ontario
N3R 1G9