camh

BI-DIRECTIONAL CONSENT FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I _____
Client/Patient Name: (Print Last Name, First Name)

hereby authorize _____ to disclose and receive personal health information

to/from Sexual Behaviours Clinic - Centre for Addiction and Mental Health (CAMH)
Name of Person/Agency Requesting/Disclosing Information

of 1001 Queen Street W. Toronto Ontario M6J 1H4
Street Address City Province Postal Code

from the records of:

_____ _____ _____
Print Client/Patient Name Date of Birth (dd/mm/yyyy) Health Card #

_____
Street Address City Province Postal Code

I consent to the following specific information to be disclosed (please check all appropriate items):

- ☐ Mental health/addictions admission history
- ☐ Medical history (including lab results, ECGs, and urine drug screens)
- ☐ Progress notes during the time period below
  _____
- ☐ Medical and/or psychiatric consultation reports
- ☐ Discharge summary
- ☐ Medications summary
- ☐ Other (Please Specify):_____

How may this information be released (choose all that apply)? ☐ Verbally ☐ Photocopy

_____ _____
Signature of Witness Signature of Client/Patient

_____ _____
Print Name of Witness (if other than client/patient, print name and state relationship)

Date: _____
(dd/mm/yyyy)

Additional Instructions: _____

This authorization may be withdrawn in writing at any time.
All Consent for Disclosure of Personal Health Information forms must be delivered to the Health Records department to be processed. An administrative fee may be applied to cover photocopying and related costs.

FOR INTERNAL HEALTH RECORDS/CLINICAL STAFF USE ONLY
INFORMATION RELEASED BY: ☐ Verbal Communication ☐ Mail ☐ Fax

F0140-20060825