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)*

*CON DISCLOS*