

PART A: Patient Contact Information

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Last Name	First Name	Initials
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Mailing Address

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Telephone Number	Date of Birth	Hospital ID Number
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**Substitute decision-maker, your contact information if applicable:**

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Last Name	First Name	Initials
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Mailing Address

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Telephone Number

**NOTE:** Include copies of documents that provide your authority as a substitute decision-maker.

PART B: Disclosure of Personal Health Information

Check the appropriate box:

<ul style="list-style-type: none"><li><input type="checkbox"/> Medical Information – all; or</li><li><input type="checkbox"/> Visit/contact dates</li><li><input type="checkbox"/> Notes/summary report</li><li><input type="checkbox"/> Intervention/procedure report</li><li><input type="checkbox"/> Progress notes</li><li><input type="checkbox"/> Diagnostic: lab results</li><li><input type="checkbox"/> Diagnostic: x-ray, MRI, CT</li><li><input type="checkbox"/> Other, please describe/list</li></ul> <hr/> <hr/> <hr/>
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<ul style="list-style-type: none"><li><input type="checkbox"/> Psychiatric Information – all; or</li><li><input type="checkbox"/> Visit/contact dates</li><li><input type="checkbox"/> Notes/summary</li><li><input type="checkbox"/> Diagnostic: lab results, x-ray</li><li><input type="checkbox"/> Initial/preliminary assessment</li><li><input type="checkbox"/> Behaviour plan</li><li><input type="checkbox"/> Service progress information</li><li><input type="checkbox"/> Other, please describe/list</li></ul> <hr/> <hr/> <hr/>
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I understand that the personal health information is to be used only by the recipient for the purpose of:

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PART C: Authorized Disclosure

- a) The Brightshores Health System - \_\_\_\_\_ site, is hereby authorized to disclose to \_\_\_\_\_.
- b) The Brightshores Health System - \_\_\_\_\_ site, is hereby authorized to obtain from \_\_\_\_\_.

I hereby waive any and all claims against \_\_\_\_\_ in connection with the disclosure of this personal health information.

Signature Patient or Substitute Decision Maker:	DATE:
Signature Witness:	DATE:
Name of Witness:	DATE:

