TIMISKAMING
HOME SUPPORT / SOUTIEN À DOMICILE

TEMISKAMING
HOSPITAL

CANADIAN
RED CROSS

CONSENT TO RELEASE OF INFORMATION

Name
D.O.B. Health Card#
Address
Telephone number:
Alternate contact:
Alternate contact telephone number:

Release of Information

By signing this form, you agree that the Temiskaming Hospital, the Timiskaming Home Support, and the Canadian Red Cross Society may release and share your personal health information with each other for the purpose of providing you with service through the PATH Program.

Signed declaration:

I understand the purpose for which my personal health information is being collected, used, and disclosed. I understand that this consent may be revoked by me at any time except to the extent that action has been taken and that it is limited to a 90 day period commencing from the date signed, after which it becomes null and void.

Client_____ Date_____

POA/SDM_____ Date_____

Discharge Planner/Home & Community CC_____ Date_____