



Saskatoon Health Region
 Health Record Services
Consent for Disclosure of Personal Health Information

I request and authorize that Saskatoon Health Region disclose copies of records containing personal health information from the following site(s):

- Royal University Hospital Saskatoon City Hospital St. Paul's Hospital
 Other _____

Patient/Client/Resident Name: (Please print) _____

Address: _____

City: _____ Postal Code: _____ Telephone # _____

Date of birth (dd/mm/yyyy) _____ Health Services Number: _____

Please disclose this information to:

Name: _____

Organization/Company (if applicable): _____

Address: _____

City: _____ Postal Code: _____

Telephone Number: _____

Information to be disclosed:

- Any and all information
 Specific Information – please specify (including dates): _____

Saskatoon Health Region, affiliates, and employees are relieved of any responsibility of liability resulting from reproduction or further use of the disclosed information.

Fees will be charged in accordance with Health Information Services policy.

Name* (please print): _____

Signature: _____

Date: _____

* if signing on behalf of patient/client/resident, please provide legal authorization to act on his/her behalf (e.g. guardian, executor). Documentation may be required.

Submit requests by mail or fax to: Health Record Services
 c/o Saskatoon City Hospital
 Saskatoon Health Region
 701 Queen Street
 Saskatoon, SK S7K 0M7

Fax: (306) 655-8727