

ACUTE CARE TO INPATIENT REHAB/CCC REFERRAL FORM

SECTION 6: CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

To be completed for all referrals (by Social Worker/Discharge Planner/Case Manager):

- I agree that _____
 (Name of facility disclosing information)
 may release my personal health information to make a referral.

Organizations referred to:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Baycrest | <input type="checkbox"/> Markham Stouffville Hospital | <input type="checkbox"/> St. John's Rehab Hospital | <input type="checkbox"/> West Park Healthcare Centre |
| <input type="checkbox"/> Bridgepoint Health | <input type="checkbox"/> Providence Healthcare | <input type="checkbox"/> Toronto East General Hospital | <input type="checkbox"/> William Osler Health Centre |
| <input type="checkbox"/> Credit Valley Hospital | <input type="checkbox"/> Rouge Valley Health System | <input type="checkbox"/> Toronto Grace Health Centre | <input type="checkbox"/> York Central Hospital |
| <input type="checkbox"/> Halton Healthcare Services | <input type="checkbox"/> Runnymede Healthcare Centre | <input type="checkbox"/> Toronto Rehab | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Lakeridge Health | <input type="checkbox"/> St. John's Rehab Hospital | <input type="checkbox"/> Trillium Health Centre | |

To be completed for all referrals:

Print Name of Patient: _____

Signature of Patient/Substitute: _____ Date:(YYYY/MM/DD) _____

Name of Substitute: _____
 (print name)

Relationship to patient, if signed by Substitute: _____

- Yes, an interpreter was used when consent was obtained.
 No interpreter was required.