

**AUTHORIZATION FOR RELEASE OF
CONFIDENTIAL PERSONAL
HEALTH INFORMATION**

I hereby authorize _____
name of facility/agency releasing information

to release personal health information in my medical/clinical records and the *ABI Client Community Profile / ABI Service Referral Form for Physicians / Internal Transfer Report* form(s) of

name of patient /client

to: Toronto Acquired Brain Injury Network and

names of institution(s)/agency(s) requesting information

I understand that this information is to be used by the recipient(s) for the purpose of facilitating a referral; for aggregate data reporting and potentially, for research*.

Expiration Date of Authorization: _____
year / month / day

print name

signature

Date: _____
year / month / day

Relationship if signed by other than the patient/client: _____

Witness: _____
print name

signature

Date: _____
year / month / day

**Summaries of this information may be used to identify trends in use of health services and to help answer research questions about brain injury and the course of treatment. No identifying information will be released other than what is needed for placement purposes as specified above.*