



**Consent for Disclosure of Personal Health Information**

Form MS 704 A (Rev 06.2020) Page 1 of 2

**Clearly Imprint Patient Identification**

- Mount Sinai Hospital**  
600 University Avenue, Room 182  
Toronto, ON, Canada M5G 1X5 T: (416) 586-4800, Ext. 2651 F: (416) 586-3181  
Email: Release.ofInformationMSH@sinaihealth.ca
- Bridgepoint Active Health Care**  
1 Bridgepoint Drive, Room A3.C85-1  
Toronto, ON M4M 2B5 T: (416) 461-8251, Ext. 2040 or 2299 F: (416) 470-6739  
Email: HealthRecords@sinaihealthsystem.ca

**Delivery**

**Please select the preferred delivery format of the record (see delivery conditions and fees on the back of this form):**

- Paper Copy       USB Key       Email       Mail       Pick-up  
 CD       Fax       In person review (a copy is not provided)

**Reason**

**Please select the reason for the request (see documentation requirements on the back of this form):**

- Personal (patient/SDM)       Medical (health care provider)       Legal       Insurance       Estate Settlement  
 Other (provide additional details) \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Health Card #: \_\_\_\_\_  
LAST NAME FIRST NAME (YYYY MM DD)  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_ Country: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Telephone #: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Fax #: \_\_\_\_\_

**Requested Information**

**Please provide any relevant details that may assist in identifying the location of the record (e.g. name of health care provider(s) or clinic(s), type of service, date ranges, etc.):**

\_\_\_\_\_

\_\_\_\_\_

**Treatment or Admission Dates:**

1. Date of Visit: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_  
(YYYY MM DD) (YYYY MM DD)  
 2. Date of Visit: \_\_\_\_\_ Date of Discharge: \_\_\_\_\_  
(YYYY MM DD) (YYYY MM DD)

**Recipient Information**

**Complete this section only if the request involves sending the record to an individual other than the above listed patient. I authorize Sinai Health System to disclose personal health information to:**

Recipient Name: \_\_\_\_\_ Name of Organization: \_\_\_\_\_  
LAST NAME FIRST NAME  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Province: \_\_\_\_\_ Country: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Telephone #: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Fax #: \_\_\_\_\_

**Consent**

**This form must be signed by the patient or the Substitute Decision Maker (SDM) in order to process the request for records. I have read and agree to the conditions outlined on the back of this form.**

Print name of Patient: \_\_\_\_\_ Print name of Substitute Decision Maker (if applicable): \_\_\_\_\_

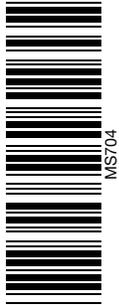
Signature of Patient: \_\_\_\_\_ Signature of Substitute Decision Maker (if applicable): \_\_\_\_\_

Date of Signature: \_\_\_\_\_

(YYYY MM DD)

Substitute Decision Maker Contact information (if different than patient):

Address and /or Telephone Number



**INSTRUCTIONS**

1. **Where to Submit Request:** Please submit the completed form in person or by email, fax or postal mail to the appropriate department as outlined below:
  - a. **Mount Sinai Health Record Services** is able to provide copies of records for Mount Sinai inpatient, emergency department and day surgery visits only.
  - b. Mount Sinai Outpatient Clinics (e.g. Family Health Team, Prenatal Clinic, Fracture Clinic) are each able to provide copies of records for their individual clinic.  
*Visit the Mount Sinai website (<http://www.mountsinai.on.ca/patients>) or call the main hospital phone line (416-586-4800) to obtain the appropriate clinic contact information. It is recommended that you contact the clinic directly for further information before submitting this form. Please note that it may be necessary to reach out to multiple clinics depending on where care was received.*
  - c. **Mount Sinai Medical Imaging** is able to provide copies of images and reports for Mount Sinai medical imaging visits.  
*For further information about requesting records, please contact (416) 586-4800 Ext. 4425.*
  - d. **Bridgepoint Health Record Services** is able to provide copies of records for all Bridgepoint inpatient and outpatient visits.
2. **Documentation Requirements:**
  - a. A copy of the patient's government issued identification must be submitted with this form (i.e. driver's licence or health card).
  - b. If the recipient listed on this form is not the patient, a copy of the recipient's government issued identification must also be submitted with this form.
  - c. Estate settlement requests require a copy of the first and last page of the will or the certification of appointment.
  - d. Legal and Insurance requests require a formal letter of request and copy of patient consent.
3. **Fees:** There are set fees related to requests for patient records, which are estimated after receiving all required documentation. Please contact Health Records if you require more information about the fees.
4. **Delivery Conditions:**
  - a. Records provided on paper, USB or CD are sent by regular postal mail.
    - i. If you wish to pick up the records in person, please specify this on the form.
    - ii. Mount Sinai records can be made available on CD, USB or Email if the visit occurred after January 1, 2014.
    - iii. Only paper copies of records (no CD, USB or Email) are available from Bridgepoint.
  - b. Regardless of the delivery method, the recipient is responsible for protecting records from unauthorized use or disclosure.
5. **Timeline for Response:** Please allow 30 days for your request to be processed. If additional time is required, you will be notified.
6. **Expiry:** This form is valid for three (3) months after the date of signature unless otherwise specified. The request may be withdrawn in writing at any time. Records that are provided in electronic format are not encrypted.