



## Consent For Disclosure Of Personal Health Information

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_

To obtain information from: \_\_\_\_\_

And/Or

Provide information to: \_\_\_\_\_

From the records of \_\_\_\_\_  
Name of Patient Birthdate

Mailing address of patient: \_\_\_\_\_  
\_\_\_\_\_

I understand this information is to be used **only** by the recipient for the purpose of:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby waive any and all claims against **York Central Hospital** in connection with disclosure of this personal health information.

\_\_\_\_\_  
Signature of Patient/Substitute Decision Maker (SDM) Print Name Date

\_\_\_\_\_  
If signed by SDM, state relationship to patient

\_\_\_\_\_  
Signature of Witness Print Witness Name

This request must be signed by the patient, or the parent or guardian if the patient is under sixteen years and unmarried, or by the personal representative (executor/administrator) if the patient is deceased.

