

Authorization to Disclose Personal Information

Date: _____

Patient Name: _____ Name of Requestor: _____
(if different than patient)

Email Address: _____

Home Address: _____ Location of the Incident/Accident: _____

Phone Number: _____ Date of the Incident/Accident: _____

I _____ print your name here hereby authorize the City of Toronto, Toronto Paramedic Services to disclose personal information regarding _____ print patient name here to the following individual(s)/organization(s):

List name and address of person/agency information being disclosed to:

I authorize Toronto Paramedic Services to release the following information:

List the personal information to be disclosed:

Note: This authorization must contain the original signature of the patient; or legal guardian if the patient is under 16 years of age and unmarried; or the legal representative if the patient is deceased or has been certified mentally incompetent.

Please send this completed and signed document to: _____
ems-psu@toronto.ca or Toronto Paramedic Services, Professional Standards
4330 Dufferin Street
Toronto, ON M3H 5R9

Name (please print)

Witness Name (please print)

Signature

Witness Signature

Relationship if signed by other than Patient (eg. legal guardian, power of attorney, estate trustee, etc.)(please print)

Date