Congenital Heart Surgeons' Society
The Hospital for Sick Children
555 University Ave Room 4433
Toronto Ontario M5G 1X8
Toll Free 1-866-477-2477 fax 416-813-8776
www.chssdc.org email :chss.dc@sickkids.ca

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize _____
(Name of facility releasing information)

to release to **CHSS Data Center at The Hospital for Sick Children, 555 University Avenue, Room 4433, Toronto, Ontario, M5G 1XB, Canada**.

(Person/Facility to whom information is to be sent- Name, Full Address)

The following information _____
(Description of information to be released)

From the record of _____
(Patient's Name, Address, Phone Number)

Date of Birth (YYYY-MM-DD) _____ Medical Record Number _____

_____

The reason for this request is: To update information for [*state Name of Study*]

_____	_____
Print Name of Patient	Signature of Patient & Date (≥ 12 years old, as applicable)
_____	_____
Print Name of Parent [Substitute Decision Maker (SDM)] and Relationship	Signature of Parent [SDM] & Date
_____	_____
Print Name of Witness	Signature of Witness & Date