



Consent to Create User Account for Patient Connect

1. Patient Information			
Last Name		First Name	
Date of Birth (DD/MM/YY)	Health Card #	MRN #	Account #
Address			
City	Province	Country	Postal Code
Phone # (Best Daytime):		Alternate #:	
2. Signatures			
<p>I hereby authorize Health Information Management of the SHINE Partner Hospitals to create a user account for Patient Connect.</p> <p>SHINE Partner Hospitals are: Markham Stouffville Hospital Southlake Regional Health Centre Stevenson Memorial Hospital</p>			
_____		_____	
Print Name of Patient		Print Name of Witness	
_____		_____	
Signature of Patient		Signature of Witness	
_____		_____	
Date		Date	

