

Authorization for Release of Personal Health Information

I hereby authorize: _____
(Name of person/facility releasing information)

To release to: _____
(Name/Address of
Person Receiving
Information) _____

The following information: _____

Relating to treatment received on: _____
(date of treatment)

From the records of: _____
(print name of individual)

(address)

(date of birth) (Health Card Number)

I understand this information is to be used by the recipient for the following purpose(s):

Signature of individual/
Legal representative: _____ Date: _____

Relationship (if not applicant): _____

Signature of Witness: _____ Date: _____

Print name of witness: _____

Notes:

1. This authorization is valid for a period of 90 days from the date of signing and may be rescinded or amended in writing during that period except where action has been taken based on authorization provided;
2. This authorization must contain the original signature of:
 - a) the individual, parent or legal guardian if the individual is under 16 years of age and unmarried; or the legal representative if the individual is deceased or has been certified mentally incompetent;
 - b) the witness to the individual's signature;
3. This authorization shall apply only to information dated prior to date of signature;
4. If the individual does not read or understand English, the authorization form must be interpreted for the individual. The person who acts as the interpreter must sign the form as a witness to confirm that this has been done.
5. The individual may withdraw this consent at any time.