NORTHUMBERLAND HILLS
HOSPITAL

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize_____
(name of facility releasing information)

to release the following information_____
(description of information to be disclosed)
_____

Concerning treatment on _____
(date *or* date range of records from treatment / hospitalization to be released)

to_____
(name *and* address of person/agency requesting information)

from the record_____ _____
(name of patient) (date of birth)

_____
(address of patient)

I understand that this information is to be used by the recipient for the purposes of _____

_____

Date:_____ Expiry of Authorization:_____

Requestor:_____ Witness: _____

_____ Signature: _____
(relationship, if other than patient) (witness)

Signature :_____
(requestor)

Note: 1. This authorization must contain the ORIGINAL signature of:

a) the patient;
the parent 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; and

b) the witness to the patient's signature.

2. The authorization may be rescinded or amended in writing at any time prior to the expiration date, except where action has been taken in reliance on the authorization.

Note 1a) Ref. Public Hospitals Act, Reg. 965, S. 22,6c (i), (ii), (iii)

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