NORTHUMBERLAND HILLS HOSPITAL

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize _____
(name of facility releasing information)

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

_____,

concerning treatment on_____,
(date *or* date range of records from treatment/hospitalization to be released)

to_____
(name, address, telephone and fax number of person/agency requesting information)

_____

from the records of_____ _____
(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 _____

_____.

Requestor: _____ _____
(please print) (authority/relationship, if other than patient)

Signature: _____ Telephone No.: _____
(requestor) (requestor)

Witness: _____ Signature: _____
(please print) (witness)

Date: _____Time:_____ Expiration: _____

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* incompetent; 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. This authorization may be rescinded or amended in writing at any time prior to the expiration date, except where action has been taken in reliance on the authorization.
3. This authorization is valid for a period of 90 days from the date of signing, unless otherwise indicated.
4. This authorization shall apply only to information dated prior to the date and time of signature.

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