**Authorization for Disclosure of Medical Record Information**

Patient’s Name:

Last Name Given Name Middle Init. HR# DOB (yyyy/mm/dd)

Address: Telephone #:

Street City Province

The undersigned hereby authorizes/requests the:

Health Care or Health Services Provider

To provide:

Name of Third Party

Address:

Street City Province Postal Code

With access to/or photocopies from (circle which) my medical records. The reason for this request is:

**The records I authorize to be accessed or photocopied are as follows:**

❑ All records

❑ For review only

❑ Only records relating to the following treatment or admission:

Type of Treatment: Dates of Treatment:

Expiration Date (6 months or as stated):

Signature of Patient Signature of Witness Date

**If the Person Signing Is Not the Patient, State Relationship and Authority To Do So**

Signature of Legal Representative Relationship Name of Witness (print) Date

* This authorization may be rescinded or amended in writing at any time prior to the expiration date except where action has been taken in reliance on the authorization.
* This authorization must contain the original signature of:
* The patient, or 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
* The witness to the patient’s signature.
* Requests for release of information must be dated after treatment dates.
* If the patient does not read or understand English, the authorization form must be interpreted for the patient. The person who acts as the interpreter **must** sign the form as a witness to confirm that this has been done. Please indicate if the interpreter is related to the patient.

Verification

❑ Photo Identification checked by Whom:

Date: