RENFREW VICTORIA 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)

to _____

_____
(Name and address of person/agency requesting information)

from the records of _____ _____
(Name of patient) (Date of birth)

_____ _____
(OHIP# or Hospital CPI#) (Address of patient)

Consisting of any visits I made/make to Renfrew Victoria Hospital between the dates of:

_____ and _____
(Start Date) (End Date)

I understand that this information is to be used by the recipient for the purpose of:

_____

Date: _____ Expiry Date of Authorization _____
(90 days from dated signature)

I hereby waive any and all claims against the Renfrew Victoria Hospital, it's Board of Directors, its physicians and its employees, officers and agents in connection with the release and disclosure of the above described information.

Signed by: _____
(Relationship if signed by other than patient)

_____

Witness: _____
(Signature) (Print Name of Witness)

Note:

1. This authorization must contain the original signature of:
   - The patient
   - The parent or legal guardian if the patient is under 16 years of age and unmarried; or
   - The executor or administrator of the patient's estate with written proof of that person's status if the patient is deceased.
   - The legal representative if the patient has been certified mentally incompetent; and
   - The legal representative if the patient is deceased or has been certified mentally incompetent and
   - ***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 This authorization may be rescinded or amended in writing at any time prior to the expiration date except where action has been taken in reliance on the authorization.