Dryden Regional Health Centre
hospital and community care

For internal use only
ID # _____

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I, _____hereby authorize Dryden Regional Health Centre to release information from the records of:

_____
(Name of patient)

_____ / _____
(Address of patient) (Ph. Number)

_____
(Date of Birth)

concerning treatment received on: _____

To _____
(Name and address of third party)

For the purposes of _____
and by whom no further release or disclosure will be authorized without further written consent.

Signed by:_____ Date:_____
(Patient/legal guardian)

_____
(relationship if other than patient)

Witness: _____

Title/address of witness:_____

i) This authorization will remain valid for a period of ninety (90) days from this date, however it may be rescinded or amended in writing at any time prior to the expiration date, except where action has been taken in reliance on the authorization.

ii) Authorization must be signed by the patient or by the legally authorized representative in the case of a minor, certified mental incompetence or death.

AUTHORIZATION MUST BE COMPLETED IN FULL AND THE ORIGINAL MUST ACCOMPANY THE REQUEST FOR INFORMATION. A PHOTOCOPY OF THE SIGNED AND COMPLETED CONSENT WILL NOT BE ACCEPTED.

ID Check Checked by: _____ ID Type: _____

ID #

Dryden Regional Health Centre
hospital and community care

Dryden Regional Health Centre
58 GOODALL STREET, P.O. BOX 3003, DRYDEN, ONTARIO P8N 2Z6
TELEPHONE (807)223-8200 MAIN FAX (807)223-2370
ADMINISTRATION FAX (807)223-8628

REQUEST FOR RELEASE OF INFORMATION
CLIENT INFORMATION / WAIVER

RE: _____

DOB: _____

The following medical information has been photocopied from your patient record and given to you at your request. According to the law, you have the right to access most of the information in your record, but we would like to point out the following to you:

1. Patient records are the property of the Dryden Regional Health Centre. The original papers in your record are the only legal documents.
2. The Dryden Regional Health Centre can not be held responsible for changes made to the photocopies and their subsequent use.
3. Medical terminology, abbreviations, signs, descriptive language, etc., are used in patient records and can be misinterpreted by those unfamiliar with the medical profession.
4. The information contained in the papers copied for you is confidential and the Dryden Regional Health Centre can not be held responsible for any information released by you to non-professional people who may or may not use the information to your benefit.

Please sign below having read and understood the above.

_____ _____

Signature of Patient/Legal Guardian Signature of Witness

Date Date

_____ _____

L:medicalrecords/releaseofinformation/waiver