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 health 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 ___PERSONAL RECORDS_____
and by whom no further release or disclosure will be authorized without further written consent.

Fee Schedule:

- $30 for the first 20 pages, and
- 25 cents per page thereafter.

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i) This authorization will remain valid for a period of ninety (90) days from this date, however it may be rescinded or amended in writing at any time prior to the expiration date, except where action has been taken in reliance on the authorization.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