Authorization for Release of Patient Personal Health Information

I hereby authorize _____
(name of party releasing information)

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

_____

to _____
(name and address of party requesting information)

from the records of: _____
(client's name, date of birth)

Concerning:

☐ Further medical care ☐ Legal ☐ Insurance Forms/Claims

☐ Estate (consent from Executor is required, with proof of executorship)

☐ Other - If other, please specify_____

_____

Preferred Method of Release:

☐ Mail ☐ Courier ☐ Pick-up ☐ Email ☐ Other _____

Signature of Client or Client's Representative: _____

Witness Signature: _____

Dated this _____day of_____ in the year _____
(day) (month) (year)

Note: Authorization must be signed by the client's legally authorized representative in the case of a minor, incapacity or death.

Ontario