ROSS MEMORIAL
HOSPITAL
Kawartha Lakes

Tel. (705) 324-6111 Fax (705) 328-6156
10 Angeline St. N., Lindsay, Ontario K9V 4M8

# *AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION*

I hereby authorize______________________________________________________________
*name of facility releasing information)*

To release to __________________________________________________________________
*(name of person/facility requesting information)*

_________________________________________________________________________________

The following information ______________________________________________________
*(description of information to be released)*

_________________________________________________________________________________

From the records of _____________________________________________________________
*(name of patient)*

________________________________ ________________________________________
*Date of birth of patient* *Approximate date of visit or admission*

***The hospital's policy specifies that an authorization for release of patient information is valid for three months. Authorization for release of information can be withdrawn at any time by notification in writing to the Director of Health Records.***

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____________________________________________ _______________________________
*Signature of patient or Authorized Person** *Date (Year, Month, Day)*

____________________________________________ _______________________________
*Signature of Witness* *Date (Year, Month, Day)*

____________________________________________ _______________________________
*Print name of Witness* *Telephone # of Patient*

***If Authorized person is not the patient, state relationship** _____________________________________