Norfolk GENERAL HOSPITAL
HEALTH RECORDS DEPARTMENT

365 West Street, Simcoe, ON. N3Y 1T7
Phone: (519)426-0750 Ext.1491 / Fax: (519)429-6987

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize 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)*

_____

(Address of Patient)

concerning treatment on _____

(Dates of Contact/Hospitalization)

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

_____

_____

Date: _____ Expiry Date of Authorization: _____

Signature: _____ Relationship: _____

(if signed by other than patient)

Signature of Witness: _____

*Contact #:*_____ *Name(if different than above):*_____

NOTE

This authorization may be rescinded or amended in writing at any time prior to the expiration date, except where action has been taken in reliance on the authorization

REV. July 2008