Norfolk GENERAL HOSPITAL

365 West Street, Simcoe, ON. N3Y 1T7

Phone: (519)426-0750 Ext.1491 / Fax: (519)429-6987

HEALTH RECORDS DEPARTMENT

AUTHORIZATION FOR RELEASE OR DISCLOSURE OF PATIENT INFORMATION

*** REQUESTS MAY TAKE UP TO 30 DAYS TO PROCESS**

I, ______________________________ hereby authorize the Norfolk General Hospital to release the following health information *(Please provide a description of the information to be disclosed)* : ___________

____

____

to: *(Please provide the name, address, and phone number of the person/agency requesting this information)*

____

____

ROI.CON.HREC

From the records of:

Name of Patient: ________________________ Date of Birth: ______________

Address: ____

Health Card Number: ____________________ Phone Number: ________________

Dates of Hospitalization or Visit: ____________________________________

The purpose of this request is: ☐ Circle of Care ☐ Lawyer ☐ Insurance ☐ Personal Use

Other: ____

I hereby waive any and all claims against the Norfolk General Hospital in connection with the disclosure of this personal health information.

Signature *(patient or substitute decision-maker)*: _________________________________

Print Name & Relationship *(if not signed by patient)*: ______________________________

Signature of Witness: ____

Date (DD-MM-YYYY):__________________ Contact Number:_________________________

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Note: This authorization may be rescinded or amended in writing at any time prior to the expiration date, except where action has been taken in reliance on the authorization