ALEXANDRA MARINE & GENERAL HOSPITAL
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Addressograph

Approved by: Corporate Leadership	Original Date: June-18-2012	Revised Date: August-27-2015

Health Records:
Authorization for Disclosure of Medical Record Information

Patient's Name: ____

Last Name Given Name Middle Init. HR# DOB (yyyy/mm/dd)

Address: ______________________________________ Telephone #: ____________

Street City Province

The undersigned hereby authorizes/requests the: ______________________________

Health Care or Health Services Provider

To provide: ____

Name of Third Party

Address: ____

Street City Province Postal Code

With access to/or photocopies from (circle which) my medical records. The reason for this request is:

____

The records I authorize to be accessed or photocopied are as follows:

- ❑ All records
- ❑ For review only
- ❑ Only records relating to the following treatment or admission:

Type of Treatment: ____________________ Dates of Treatment: ____________________

Expiration Date (6 months or as stated): ______________________________

Signature of Patient	Signature of Witness	Date

IF THE PERSON SIGNING IS NOT THE PATIENT, STATE RELATIONSHIP AND AUTHORITY TO DO SO

Signature of Legal Representative	Relationship	Name of Witness (print)	Date

- This authorization may be rescinded or amended in writing at any time prior to the expiration date except where action has been taken in reliance on the authorization.
- This authorization must contain the original signature of:
  - The patient, or the parent or legal guardian if the patient is under 16 years of age and unmarried; or the legal representative if the patient is deceased or has been certified mentally incompetent, and
  - The witness to the patient's signature.
- Requests for release of information must be dated after treatment dates.
- If the patient does not read or understand English, the authorization form must be interpreted for the patient. The person who acts as the interpreter **must** sign the form as a witness to confirm that this has been done. Please indicate if the interpreter is related to the patient.

Verification

❑ Photo Identification checked by Whom: ______________________________

Date:

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