AUTHORIZATION TO RELEASE INFORMATION FROM A HEALTH RECORD

Please print clearly

Name of Patient: _____

Date of Birth of Patient: _____

Family Doctor (if applicable): _____

Address of Patient:

_____

_____

OSMH I.D.# _____

Authorization is hereby granted to release:

_____

_____

_____

TO:

_____

I understand that the information may be faxed in the interests of time. I hereby waive any and all claims against the said Hospital, its doctors, employees and agents for all purposes whatsoever in connection with the said communication and disclosure of information in the Said record.

Signed at _____ Hrs. this _____ day of _____ 20____

Expiry Date of Authorization _____

Signature of Patient_____

Witness Signature_____

NOTE: For unmarried patients under 16 years of age the signature of a parent or guardian is required.

Signature of Parent/Guardian_____

Relationship to Patient_____