Soldiers' MEMORIAL HOSPITAL Orillia

Patient Information (please print):

Patient's Last Name | First Name | Middle name(s)

Telephone Number | Date of Birth | MRN

If you are the patient's substitute decision-maker, your contact information:

Last Name | First Name

Telephone Number | Relationship to the patient

Authorization is hereby granted to release (check one):	☐ **Any information requested** **or** ☐ **Certain Information (list information):**
To (name person/agency):	

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.

Date Signed: _____ Expiry Date of Authorization (if any): _____

Signature of Patient/
Substitute Decision Maker: _____

Witness Signature:_____

Printed Name of Witness: _____