Kirkland and District Hospital

145 GOVERNMENT ROAD EAST
KIRKLAND LAKE, ONTARIO, CANADA
P2N 3P4

HEALTH RECORDS
TELEPHONE: 705-568-2125
FAX: 705-568-2103
WEB SITE: www.kdhospital.com/privacy
E-MAIL: privacy@kdhospital.com

I, ___________________________________, hereby authorize the Kirkland and District Hospital, to

release the following information ____, to
(description of information to be disclosed)

____
(name, address, phone, fax numbers of physician or organization receiving information)

from the records of: ____________________________ __________________________
(name of patient) (DOB)

____
(address and telephone numbers of patient)

I understand this information is to be used by the recipient for the purposes of further treatment of the patient or examination of records.

Date:_____________________ Expiry Date of Authorization: ___________________________

Signed by: ____

Signature of Witness: ____

IF NOT SIGNED BY THE PATIENT, INSERT THE FOLLOWING INFORMATION:

____

Name and Address of Signatory (The hospital may require legal documentation providing right to sign i.e. "Substitute Decision Maker", " Custodial Parent", " POA for personal care or property", "Certificate of Appointment of Estate Trustee with a Will" or "Certificate of Appointment of Estate Trustee without a Will."

__________________________________ __________________________________
(Relationship to patient) **(Date)**

Working Together to Meet YOUR Health Care Needs