Kirkland and District Hospital

HEALTH RECORDS
145 GOVERNMENT ROAD EAST – POSTAL BAG SERVICE 3000
KIRKLAND LAKE, ONTARIO, CANADA
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EUGENE IVANOV
CHAIR OF THE BOARD

H.L. (HAL) FJELDSTED
CHIEF EXECUTIVE OFFICER

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WEB SITE: www.kdhospital.com/privacy
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AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize ____
(Name of Facility releasing information)

to release the following information ____

____
(Description of information to be disclosed)

from the records of ___________________________ ___________________________
(Name of patient) (Date of birth)

____
(Patients Address)

concerning treatment on ____
(Dates of Contact/hospitalization)

I understand that this information is to be used by the recipient for the purposes of:

____

Date: ________________________ Expiry Date of Authorization: ______________________

Signed by: ____

Signature of Witness: ____

IF NOT SIGNED BY PATIENT, INSERT THE FOLLOWING INFORMATION:

____
Name of Signatory (The hospital may require legal document providing right to sign i.e. “Certificate of Appointment of Estate Trustee with a Will” or “Certificate of Appointment of Estate Trustee without a Will.” If no will, the person notes on the record as Next of Kin, or Executive of Estate.

____
Relationship to patient

____
Address

Working Together to Meet YOUR Health Care Need