WINDSOR REGIONAL HOSPITAL

# AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

I hereby authorize _____ to release the following information:

_____
(Description of information to be disclosed)

to _____
(Name and address of person/agency requesting information)

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

_____
(Address of patient)

concerning treatment on or around _____
(Date(s) of contact/hospitalization)

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

_____

Date: _____ Expiry Date of Authorization: _____
(Not to exceed 90 days)

Signed by: _____

_____
(Relationship if signed by other than patient)

Signature of Witness: _____

Address of Witness: _____

**********

**NOTE:** 1. This authorization must contain the **ORIGINAL** signature of:
a) the patient:
the parent or legal guardian if the patient is under sixteen (16) years of age and unmarried; or
the legal representative if the patient is deceased or has been certified mentally incompetent; and
b) the witness to the patient's signature