West Parry Sound Health Centre
6 Albert Street
Parry Sound, ON
P2A 3A4
Telephone: 705-746-9321
Fax: (705) 773 - 4060

Authorization for Release of Patient Information

I, _____ **hereby authorize**

West Parry Sound Health Centre
(name of the Health Care Facility releasing information)

to release the following information

_____

_____

to **Physician** _____

Myself _____

Other _____

from the records of _____

Date of Birth _____
(Day/Month/Year)

I hereby release the Health Care Facility authorized to release information as named above, its employees, agents and physicians from any and all claims whatsoever which may arise as a result of the release of the above information.

I am sixteen years of age or older.

***Dated this** _____**day of** _____.

_____ _____
(Signature of Witness) (Patient's or Representative's Signature)

_____ _____
(Print Name) (Representative's Relationship to Patient)

This authorization will expire _____ **(months) from the above date* or on the** _____ **day of** _____.

MM#2709