



fraserhealth

AUTHORIZATION FOR RELEASE OF INFORMATION



HMRI000412B

Rev: Oct 29/08

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I, _____, **HEREBY AUTHORIZE:**
(Print Name)

- Hospital** _____
- Home Health** _____
- Public Health** _____
- Community/Mental Health** _____

To release the following information:

(Note approximate dates and indicate what specific information or reports are required)

Dates: _____

Type of record: _____

To me, or to: _____

(Name and address of person authorized to receive information)

from the records of: **FULL NAME:** _____

ALSO KNOWN AS: _____

CARE CARD #: _____ **BIRTHDATE:** _____
(DD/MM/YYYY)

ADDRESS: _____

CITY: _____ **POSTAL CODE:** _____

PHONE NUMBER: _____

If request is for records for an expired patient, please indicate: **Copy of Will Enclosed** **No Will**

I consent to the use of this information only for the purpose of: (optional) _____

*The applicant or authorized representative is responsible for payment of any established fees.
(as allowed by the Freedom of Information and Protection of Privacy Act.)*

DATE

(This authorization will expire in six (6) months from date signed.)

SIGNATURE of Patient/Resident/Client/Authorized Representative.
(Authorized Representative - attach a copy of your authority to act)

MAIL OUT **PICK UP**

* Legal Representative's **Relationship** to Applicant

Internal Use Only

Identification Presented (ie: DL #) _____ Viewed by: _____

Copies Released: _____ DATE: _____ # of Pages: _____

(A SIGNED ORIGINAL AUTHORIZATION MUST BE SUBMITTED)

Print Shop # 307609

AUTHORIZATION FOR RELEASE OF INFORMATION Cont'd

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GUIDELINES FOR USE

- USED BY:** Persons authorizing information from their health record to be released to themselves or another party. (applicant)
- WHEN USED:** See Health Records, Release of Information Standards Manual, for situations where a written authorization is required.
- HOW USED:**
- ◆ All sections must be completed and bear the original signature of the applicant or legally authorized representative.
 - ◆ Form must be signed by the applicant unless:
 - ◆ If applicant is deceased, form to be signed by the authorized legal representative
 - ◆ If the applicant is a minor (a mature minor may sign for him/her self) a signature is required by:
 - ◆ parent,
 - ◆ guardian ad litem*
 - ◆ Ministry of Health social worker*
(*Proof of custody is required)
 - ◆ File authorization in the patient/client/resident's record