



**AUTHORIZATION AND CONSENT TO RELEASE OF HEALTH INFORMATION**

**To Whom It May Concern:**

I, the undersigned, consent to and authorize the release of all information contained in my health records (including hospital records, physiotherapist office records, pharmaceutical prescription records and patient billing information).

**Print Full Name of Patient (s)** \_\_\_\_\_

**Patient's Health Card # (s)** \_\_\_\_\_

**Patient's Date of Birth (s)** \_\_\_\_\_

**Print Full Name of Person Giving Consent** \_\_\_\_\_

**Information to be Released to:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Name of Witness (print)**

**OR**

**Address:** \_\_\_\_\_

**Legally authorized Representative\***

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**(Signature)**

**Phone Number:** \_\_\_\_\_

\_\_\_\_\_  
**(Print Name)**

**Relationship to patient (please state)**

**Signature of Witness:** \_\_\_\_\_

(\*includes: executor or administrator of an estate, next of kin or legal guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date