Labrador-Grenfell Health

Department/Facility Information
Address
Phone #
Fax #

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Client Name: _____

Address: _____ **Tel #:** _____

Date of Birth: _____ **MCP#:** _____

I, the undersigned, authorize _____

(Name of Department and/or Facility holding the personal health information)

to release information contained in the clinical record of: _____

_____

(Client Name or "Myself")

to _____

_____

(Name & Address of Person/Agency to receive personal health information)

Information to be released will be:

( ) Regarding admission and treatment for the following medical condition or injury:
_____

_____

( ) Health records for the period of care: _____ to _____

( ) Confined to the following specific information: _____

_____

_____

Please Note: if a client requests that this information be transmitted via fax, the client must acknowledge and accept the risks as outlined by initialing statement below:

"I acknowledge and accept the privacy risks associated with the faxing my personal health information, including (but not limited to) dialing errors or the fax being retrieved by someone other than the person for whom it was intended." **( )** Client Initials

_____ _____
(Signature of Client/Parent/Legal Guardian) (Witness)

_____ _____
(Relationship to Client, i.e. 'Self') (Date)

LG Health #: LGH 330
Revised: March 2013