Charles S. Curtis Memorial Hospital
Labrador-Grenfell Health
Health Records Department
178-200 West Street
St. Anthony, NL A0K 4S0
Phone: (709) 454-0121
Fax: (709) 454-3209

# 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, and where the fax number is unknown, the client must provide this number. The client must acknowledge and accept the risks as outlined below:

***Please fax the above referenced information to the following fax number:*** _____

***"I acknowledge and accept the privacy risks associated with the faxing of 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/Legal Guardian Witness

_____ _____

Relationship to Client (i.e. 'self') Date