Kingston General Hospital

Religious Hospitallers of Saint Joseph of the Hotel Dieu of Kingston
HOTEL DIEU HOSPITAL

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

I hereby authorize Kingston General and Hotel Dieu Hospitals to release information to:

_____
(name of person/facility/agency requesting information)

_____
(address of person/facility/agency requesting information)

from the records of:
(apply pt. addressograph label if available)

Patient Name: _____

Address: _____

Date of Birth: _____
(yyyy mm dd)

The following personal health information is to be disclosed concerning treatment on/from:

☐ Hotel Dieu Hospital visits ☐ Kingston General Hospital visits

_____
(Description of personal health information and dates of contact/hospitalizations)

_____

_____

I understand that this information is to be used only by the recipient for the purposes of

_____

Date: _____
(yyyy mm dd)

Patient Signature: _____

Relationship to patient: _____

Information collected & requested by: _____
(print name and telephone or pager no.)

This authorization must contain the original signatures, photocopies will not be accepted. It is understood that this authorization may be rescinded or amended in writing at any time by the patient. This authorization automatically expires ninety days after the date signed above.