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**Kingston Health
Sciences Centre**

Centre des sciences de
la santé de Kingston



Hôpital
Hotel Dieu
Hospital



Hôpital Général de
Kingston General
Hospital

(Apply patient addressograph label if available)

AUTHORIZATION TO RELEASE MY PERSONAL HEALTH INFORMATION TO A THIRD PARTY

I authorize Kingston Health Sciences Centre (KHSC) to release the following personal health information as described below.

Describe what information should be released and include relevant dates: _____

Release to: _____
(Name/Organization)

Recipient's address & fax: _____
(Address of recipient/ person / facility / agency requesting information) (Fax number)

Patient's Information: _____
(Patient's first and last name) (Date of birth (yyyy / mm / dd))

(Patient's address) (Patient's telephone number)

Purpose of release: Ongoing Care Personal Legal Insurance Other specify: _____

Sites of care: Kingston General Hospital Site Hotel Dieu Hospital Site Cancer Centre Bayshore (AHF) site

Authorization: I, _____, have the legal authority to make this request in my capacity as:
(Print First and Last name)

- The patient
- Substitute Decision Maker* (attach proof of authority)
- Estate Trustee/Executor (attach proof of authority)

*If Substitute Decision Maker, specify:

- Custodial parent or legal guardian of an incapable youth (child under 16)
- Attorney for Personal Care of an incapable adult
- Other: _____

SIGNATURE REQUIRED:

Date (yyyy/mm/dd):

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 It is understood that this authorization may be rescinded or amended in writing at any time by the patient.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.

Submit to:

Release of Information, KHSC
Kingston General Hospital Site
76 Stuart St, Kingston, ON K7L 2V7
Fax:613-542-8071 Email: khscroirequest@kingstonhsc.ca

For more information scan this QR code or visit "My Health Care Information" at www.kingstonhsc.ca

