Kingston Health Sciences Centre
Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

(Apply patient addressograph label if available)

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

I hereby authorize Kingston Health Sciences Centre to release information to:

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

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

from the records of: Patient Name: _____

Address: _____

Date of Birth: _____
(yyyy / mm / dd)

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

HDH Site ☐ KGH Site ☐

_____
(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 number)

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 It is understood that this authorization may be rescinded or amended in writing at any time by the patient.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

Please send completed form to:
Release of Information
Kingston Health Sciences Centre
Hotel Dieu Hospital Site
166 Brock Street
Kingston, ON K7L 5G2
Fax # 613-542-8071