Authorization for Release of Patient Information

CLAIM NUMBER	DATE OF LOSS	RESOURCE NAME	RESOURCE NUMBER	LOC. CODE

I, _____,

hereby authorize _____
NAME OF HEALTH CARE FACILITY RELEASING INFORMATION

to release the following information (If authorization is given other than by patient, proof of guardianship or appointment as representative must be given.):

_____

_____

To me, or to: _____
NAME AND ADDRESS OF PERSON AUTHORIZED TO RECEIVE INFORMATION

_____

From the records of _____
PATIENT NAME

born _____ and presently residing at _____
PATIENT BIRTH DATE

_____
PATIENT ADDRESS

I consent to the use of this information by the authorized recipient only for the purposes of _____

_____

I hereby release the health care facility authorized to release information as named above, its employees and agents, from any and all claims whatsoever which may arise as a result of the release of the above information.

Information will be released only after the patient or authorized representative has paid the health care facility any fees that may be established for searching and photocopying.

I am nineteen years of age or older.

Dated this _____ day of _____.

Witness:

_____
SIGNATURE

_____
NAME

_____
ADDRESS

_____
OCCUPATION

Patient:

_____
PERSONAL HEALTH NUMBER

_____
PATIENT'S OR REPRESENTATIVE'S SIGNATURE

_____
RELATIONSHIP TO PATIENT

This authorization will expire six months from the above date, or on the _____ day of _____, _____.

Note: The description of the information to be released should include an approximate date of the clinical record and an indication of the specific information is requested from the record.

This form to be presented in duplicate to the health care facility.
The British Columbia Health Association has approved the use of this format.