Authorization For Release of Patient Information

Quinte Healthcare Corporation

- ☐ Belleville General Hospital
- ☐ North Hastings Hospital
- ☐ Prince Edward County Memorial Hospital
- ☐ Trenton Memorial Hospital

I hereby authorize _____
(name of facility releasing information)

to release the following information _____
(description of information to be disclosed and dates of contact/hospitalization)

to _____

_____
(name and address of person/agency requesting information)

from the records of _____ _____
(name of patient) (date of birth)

_____ _____
(health card # and/or hospital ID#) (address of patient)

consisting of any visits I made/make to Quinte Health Care between the dates of:

_____ and _____.
(start date) (end date)

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

_____.

Date: _____ Expiry date of authorization: _____

I hereby waive any and all claims against the Quinte Healthcare Corporation, its Board of Trustees, it's physicians and its employees, officers and agents in connection with the release and disclosure of the above described information.

Witness: _____ Signed by: _____

Date: _____ _____
(relationship if signed by other than patient)

Note:
1. This authorization must contain the original signature of: a) the patient, or (b) the parent or legal guardian if the patient is under the age of 16, or (c) the legal representative if the patient is deceased or has been certified mentally incompetent (in which case the authorization shall be accompanied by a notarial or certified copy of court document appointing the person as the legal representative of the patient).
2. This authorization may be rescinded or amended in writing at any time prior to the expiration date, except where action has been taken in reliance on the authorization.