□ **Little Current Site**
Box 640, Little Current, ON P0P 1K0
(705) 368-2300

□ **Mindemoya Site**
Box 170, Mindemoya, ON P0P 1S0
(705) 377-5311

MANITOULIN HEALTH CENTRE
www.mhc.on.ca

REQUEST FOR RELEASE OF INFORMATION

I hereby authorize the MANITOULIN HEALTH CENTRE to release the following information

_____
(Description of Information to be Disclosed)

to _____
(Name and Address of Person/Agency Requesting Information)

From the records of _____
(Name of Patient)

_____ _____
(Date of Birth) (Address of Patient)

Concerning treatment on _____
(Dates of contact/hospitalization)

I understand that this information is to be used by the recipient for the purpose of _____ and may be forwarded by Fax.

Date: _____ (expiry Date of Authorization: 30 days)

Signed By: _____

_____
(Relationship if signed other than patient)

Signature of Witness:_____

Note:

1. This authorization must contain the ORIGINAL signature of:
   a) the patient
   b) the parent or legal guardian if the patient is under 16 years of age and unmarried; or the legal representative if the patient is deceased or has been certified mentally incompetent; and
   c) The witness of the patient's signature.

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 This authorization may be rescinded or amended in writing at any time prior to the expiration date, except where action has been taken in relation to the authorization.

Required by Section 21 (4) (c) of Regulation 965 of the Public Hospital Act