RÉSEAU DE SANTÉ Horizon HEALTH NETWORK

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

FOR OFFICE USE ONLY
UNIQUE NUMBER

1. PATIENT IDENTIFICATION INFORMATION: Please complete this section with information relating to the person whose health information is being disclosed. (Please print clearly and provide as much information possible to ensure your request will be completed.)

Name: _____ _____ _____
(Last) (First) (Middle)

Current Address: _____ Date of Birth: _____
(Street/Unit/Apartment) (Day/Month/Year)

_____ Health Card #: _____
(City, Province, Postal Code)

Telephone: (____) _____ ❒ Please check box if patient is deceased

2. AUTHORIZATION TO RELEASE THE FOLLOWING PERSONAL HEALTH INFORMATION:

Please indicate the health care facility you are requesting health information from:

_____
(Name of Health Care Facility)

Specific Health Information: _____

_____

From: _____ To: _____
(Day/Month/Year) (Day/Month/Year)

❒ Is the requested health information for insurance purposes?

3. RELEASE PERSONAL HEALTH INFORMATION TO:

❒ I am requesting copies of my own record ***OR***

❒ I am authorizing release of information to the following person(s):

Name: _____

Address: _____
(Street/Unit/Apartment)

_____
(City, Province, Postal Code)

Telephone: (____) _____ Fax: (____) _____

4. HOW TO RECEIVE HEALTH INFORMATION:

❒ Pick up / Call when ready (ID required) ❒ Mail ❒ Fax: (____) _____

I HEREBY AUTHORIZE HORIZON HEALTH NETWORK TO RELEASE THE REQUESTED PERSONAL HEALTH INFORMATION AS DIRECTED ON THIS FORM. I UNDERSTAND I MAY REVOKE MY AUTHORIZATION AT ANY TIME, IN WRITING.

_____ _____
Print Name Relationship to Patient

_____ _____
Signature Date

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