STEVENSON
MEMORIAL HOSPITAL

200 Fletcher Crescent
Alliston, Ontario L9R 1W7
Tel: 705-434-5100

PATIENT LABEL

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize and instruct **Stevenson Memorial Hospital** to release any or all information pertaining to my admission, confinement and/or discharge, and any or all information contained in my records at this hospital either as inpatient or as an outpatient.

I agree that all information is released without prejudice.

TO:

_____

NAME (Indicate who records are being released to)

_____ _____ _____

PATIENT NAME **DOB** **CHART #**

_____

ATTENDING PHYSICIAN (if applicable)

_____ _____

VISIT TYPE (ie: ER, IP, DS) **REPORTS RELEASED (details of released records)**

_____

_____

_____ _____

DATE CONSENT OBTAINED (yyyy/mm/dd) **PERSON RELEASING INFORMATION**

_____

SIGNATURE OF PATIENT OR GUARDIAN

_____

WITNESS

ID Verified: ☐ Yes ☐ No

ID Verified by: *(Print first, last)*_____

FOR OFFICE USE ONLY

Total Amount: $_____	VISA/MasterCard #:_____ Expiry: _____/_____