AUTHORIZATION TO RELEASE INFORMATION CONTAINED IN THE MEDICAL RECORD

Surname and given name(s) at birth	Name now used
Present address of user	
MRN:	Birthdate (Month /Day / Year)
Surname and given name(s) of father	Surname and given names of mother
Other names used previously	

I, the undersigned,_____
Name and address

In my capacity of_____
User or person authorized

Authorize the establishment_____

To send the following information_____

to:_____

Concerning the care or services received during the following period _____

Such information in contained in the dossier of the above-identified user.

This authorization is valid for a period of_____days following the date this document was signed.

_____ _____
Signatory: user or authorized person MM/DD/YYYY

_____ _____
Witness to the signature MM/DD/YYYY

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Shriners Hospitals for Children®- Canada

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PATIENT LABEL INFORMATION