



HURON PERTH HEALTHCARE ALLIANCE

REQUEST FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION

I, hereby authorize _____
(name of facility releasing information)

to release the following information

to _____
(name and address of person/agency to whom the information is to be disclosed)

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

concerning treatment on _____
(date(s) of contact/hospitalization)

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

Date: _____ Signed by: _____

Signature of Witness: _____
(relationship if signed by
other than patient)

This information is valid for three months from the date of signing. It may be rescinded or amended in writing at any time prior to that date, except where action has been taken in reliance on the authorization.

Office Use Only: *Verification of identity of individual consenting to the disclosure:*

Form of ID: ___ Drivers License ___ Passport ___ Notarized/Lawyer's Letter ___ Other

ID Checked by: _____
Printed Name Signature