



HOTEL
DIEU
HOSPITAL



Kingston
General
Hospital

Request for Personal Health Information

I hereby authorize: _____
(name of person/facility/agency releasing information)

(address of person/facility/agency releasing information)

to release information to Hotel Dieu and Kingston General Hospitals from the records of:

(apply pt. addressograph label if available)

Patient Name: _____

Address: _____

Date of Birth: _____
(yyyy mm dd)

The following medical/surgical/psychiatric information is required concerning treatment on /from:

(Description of personal health information and dates of contact/hospitalizations)

_____ for the purposes of ongoing patient care.

Date: _____
(yyyy mm dd)

Patient Signature: _____

Information collected & requested by: _____
(print name)

Telephone or pager number: _____

This authorization must contain the original signatures, photocopies will not be accepted. It is understood that this authorization may be rescinded or amended in writing at any time by the patient. This authorization automatically expires ninety days after the date signed above.