Appendix B

island health

Program: _____

Authorization to Share Confidential Information: Release of Information

Personal Information	
Name of Person	*Date of Birth:*
	MRN:

☐ Consent to share information declined

I hereby request and authorize _____ *to release information to:*
(name of facility)

Name of person/ agency	*Relationship*	*Information that may be shared:*					
		Appointment schedule	*Medication/ side effects*	*Treatment/ Service Plan*	*Safe Exit/ Discharge Plan*	*Other (please specify)*	*Consent Withdrawn*
							☐ _____ *Signature/Date*
							☐ _____ *Signature/Date*
							☐ _____ *Signature/Date*
							☐ _____ *Signature/Date*

Additional Comments/Specific Details:

Written Authorization		Verbal authorization *(Requires two witness signatures)*	
Signature	*Date*	*Name of Person giving verbal authorization*	
Legal Guardian/ Decision Maker signature (if applicable)	*Date*	*Witness signature*	*Date*
* Proof of authority is required			
Health care provider signature	*Date*	*Witness signature*	*Date*

☐ By signing this release form, I give consent for information to be verbally released to the above-named individuals.

☐ This release form expires:

The collection of personal information provided on this form is authorized under section 26 of the Freedom of Information and Privacy Act for the purpose(s) set out below. Should you have any questions about the collection of this personal information please contact: Island Health Information Stewardship, Access & Privacy