# *CONSENT TO RELEASE PERSONAL INFORMATION*

I, _____
(Name of Client/Parent/Guardian)

authorize Hands TheFamilyHelpNetwork.ca or

_____
(Name and address of institution releasing information)

To release/forward to:

_____
Name of person or institution

_____
Address

_____
Telephone and fax number

The following personal health information (please specify)
_____
_____
_____

From the medical file of:_____
(Name of patient)

Date of Birth:_____ Unique identification no.: _____
(day/month/year)

I understand that I may revoke my consent at any time but not retroactively.

_____ Relationship to patient: _____Date: _____
Signature – Parent/Guardian(s) or patient

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**This section to be completed by HANDS**
This request was submitted by:

Name:_____ Date:_____

Service: _____