



**Authorization For Release of  
Patient Information**  
**Quinte Healthcare Corporation**

- Belleville General Hospital
- North Hastings Hospital
- Prince Edward County Memorial Hospital
- Trenton Memorial Hospital

I hereby authorize \_\_\_\_\_  
(name of facility releasing information)

to release the following information \_\_\_\_\_  
(description of information to be disclosed and dates of contact/hospitalization)

to \_\_\_\_\_  
  
\_\_\_\_\_  
(name and address of person/agency requesting information)

from the records of \_\_\_\_\_ (name of patient) \_\_\_\_\_ (date of birth)

\_\_\_\_\_ (health card # and/or hospital ID#) \_\_\_\_\_ (address of patient)

consisting of any visits I made/make to Quinte Health Care between the dates of:  
\_\_\_\_\_ and \_\_\_\_\_  
(start date) (end date)

I understand that this information is to be used by the recipient for the purposes of:  
\_\_\_\_\_

Date: \_\_\_\_\_ Expiry date of authorization: \_\_\_\_\_

I hereby waive any and all claims against the Quinte Healthcare Corporation, it's Board of Trustees, it's physicians and it's employees, officers and agents in connection with the release and disclosure of the above described information.

Witness: \_\_\_\_\_ Signed by: \_\_\_\_\_

Date: \_\_\_\_\_  
(relationship if signed by other than patient)

- Note: 1. This authorization must contain the original signature of: (a) the patient, or (b) the parent or legal guardian if the patient is under the age of 16, or (c) the legal representative if the patient is deceased or has been certified mentally incompetent (in which case the authorization shall be accompanied by a notarial or certified copy of court document appointing the person as the legal representative of the patient).
2. This authorization may be rescinded or amended in writing at any time prior to the expiration date, except where action has been taken in reliance on the authorization.