

**PATIENT AUTHORIZATION FOR THE COLLECTION/RELEASE  
OF PERSONAL HEALTH INFORMATION**

Authorization must be signed by the patient or by the legally authorized representative in the case of incompetency or death.

I, \_\_\_\_\_ hereby authorize  
(Name of Patient/Substitute Decision Maker)

**GRAND RIVER HOSPITAL** to

Release

Collect

Records pertaining to the admission(s)/ visit(s) from \_\_\_\_\_ to \_\_\_\_\_  
(yyyy/mm/dd) (yyyy/mm/dd)

compiled at: \_\_\_\_\_  
(Institution)

from the health record of: \_\_\_\_\_  
(Patient Name) (Date of Birth, yyyy/mm/dd)

Contact Phone #: \_\_\_\_\_

Leave Message: Yes  No  (Health Card Number/ Photo ID)

**REQUEST:**

Requested by (Specific Name, Unit or Dept.): \_\_\_\_\_

Requestor Agency Name & Department: \_\_\_\_\_  
(e.g. Insurance Company, Lawyer, Physician Office)

Address: \_\_\_\_\_

**PURPOSE:**

This information will be used for the purpose of:

- |  |   |
|--|---|
| <input type="checkbox"/> Further medical treatment | <input type="checkbox"/> Insurance claim                      |
| <input type="checkbox"/> Litigation                | <input type="checkbox"/> Estate settlement                    |
| <input type="checkbox"/> Physician Reference       | <input type="checkbox"/> Mental Health Assessment &/Treatment |
| <input type="checkbox"/> Other _____               |   |

**CONSENT:**

I understand the private and confidential nature of this information and agree that it will be used only for the stated purpose(s). I further absolve the information – releasing Hospital named above of any responsibility for carrying out this directive. This authorization will be valid for 90 days as of the date of signature, unless specified otherwise.

Date of Consent: \_\_\_\_\_ Signed: \_\_\_\_\_

Consent Expiry Date: \_\_\_\_\_  
(Date plus 90 days) (Relationship if other than patient)

Witness: \_\_\_\_\_ Print Name: \_\_\_\_\_  
(Signature)