



Health Records Department  
 Labrador-West Health Centre  
 Labrador West Health Center  
 1700 Nichols-Adam Highway  
 Labrador City, NL  
 Fax # 944-7439

**AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION**

**Client Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Tel #:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **MCP#:** \_\_\_\_\_

I, the undersigned, authorize \_\_\_\_\_

(Name of Department and/or Facility holding the personal health information)

to release information contained in the clinical record of: \_\_\_\_\_

(Client Name or "Myself")

to \_\_\_\_\_

(Name & Address of Person/Agency to receive personal health information)

**Information to be released will be:**

( ) Regarding admission and treatment for the following medical condition or injury:

\_\_\_\_\_  
 \_\_\_\_\_

( ) Health records for the period of care: \_\_\_\_\_ to \_\_\_\_\_

( ) Confined to the following specific information: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Please Note:** if a client requests that this information be transmitted via fax, the client must acknowledge and accept the risks as outlined by initialing statement below:

***"I acknowledge and accept the privacy risks associated with the faxing my personal health information, including (but not limited to) dialing errors or the fax being retrieved by someone other than the person for whom it was intended."*** ( )

Client Initials

\_\_\_\_\_  
 (Signature of Client/Parent/Legal Guardian)

\_\_\_\_\_  
 (Witness)

\_\_\_\_\_  
 (Relationship to Client, i.e. 'Self')

\_\_\_\_\_  
 (Date)