Lions Gate Hospital
Health Records Dpt ROI
231 15th St E
North Vancouver, V7L 2L7
Telephone: 604-984-5911 Fax: 604-984-5718

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize
(Name of Patient/Client/Guardian/Executor)

Lions Gate Hospital to release information to:

_____
(Name of Person/Company authorized to receive information)

_____
(Street Address) **(City)** **(Province)**

_____
(Postal Code) **(Phone Number)**

from the health records of_____
(Name of Patient/Client – Print in Full)

_____ _____
(Date of Birth – dd/mmm/yyyy) **(PHN/Care Card Number)**

This consent refers only to the following information:

_____

compiled during the period of_____to_____

for the purpose of_____.

I understand that once this record is released, Lions Gate Hospital, a part of the Vancouver Coastal Health Authority, is not responsible for the copy of the record, or any events caused by its subsequent release.

DATED:_____, 20_____

SIGNED: **WITNESSED:**

_____ _____
(Patient/Client/Guardian/Executor) **(Signature of Witness)**

_____ _____
(State relationship, if other than patient) **(Printed Name of Witness)**

Note: **This authorization must be signed by the patient/client/guardian/executor, and must be dated within six (6) months of the request being submitted to Lions Gate Hospital. If an authorization is given other than by the patient, proof of guardianship or appointment as the representative must be given. The Freedom of Information and Protection of Privacy Act allows VCHA thirty (30) business days to respond to all requests.**