

## Authorization to release healthcare information

Please provide the following information in order to receive your records in a timely fashion:

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

PHN #: \_\_\_\_\_

I, \_\_\_\_\_, request and authorize Shoreline Medical - Sidney  
to release my medical records to:

DR. \_\_\_\_\_

DR. Tel No: \_\_\_\_\_ DR. Fax No: \_\_\_\_\_

**This request and authorization applies to:**

Healthcare Information relating to the following treatment, conditions or dates:

\_\_\_\_\_

All Healthcare Information (2 years only)

Other:

\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**\*\*\*The applicant or authorized representative is responsible for payment of any established fees.**