AUTHORIZATION FOR REPRESENTATIVE TO ACCESS PERSONAL HEALTH INFORMATION

To whom it may concern:

I hereby authorize

First Name: _____ Last Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: _____ Cellular: _____ Relationship: _____

To exercise my rights and act on my behalf in order to access the personal health information contained in my health care records.

This authorization applies to:

- ☐ All of my health care records
- ☐ My health care records from the present day forward
- ☐ My health care records beginning _____ (mm/dd/yyyy) and ending _____ (mm/dd/yyyy)

First Name: _____ Last Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: _____ Cellular: _____ Relationship: _____

Provincial Health Care Services Number: _____

Signature: _____ Date: _____

Witness: _____ Date: _____