302 11420 27 St SE.
Calgary, AB, T2Z 3R6
Phone: 587-332-0600 | Fax: 587-332-0601 |
info@mykidz.ca | www.mykidz.ca

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:

Date of Birth:

AHC#

I request and authorize [Authorized individual] to release healthcare information of the patient named above to:

Name:
Address:

This request and authorization applies to:

○ Healthcare information relating to the following treatment, condition, or dates

____
____
____
____
____
____

○ All healthcare information ○ Other

____
____

Parents Signature: ____ Date signed: ________

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.