

*Authorization for Release of
Medical Information*



IWK Grace Health Centre for Children, Women & Families
5850/5980 University Avenue, PO Box 3070
Halifax, Nova Scotia, Canada B3J 3G9
Tel: (902) 428-8888

I do hereby give my consent to the IWK-Grace Health Centre to release _____

_____ specific information and dates

regarding _____

name of patient

date of birth

to

_____ recipient of information

_____ address

_____ postal code

for the purpose of _____

_____	_____
(Signature of person giving authorization)	Date

Address	

Telephone Number	
Relationship to patient self _____ legal guardian _____	
Witness _____	

Expiry date of consent: 90 days after date signed