



Release of Information

I, _____
(Print Client/Patient's Full Name) (Client/Patient's Date of Birth)

hereby authorize Quest Community Health Centre to request and exchange information regarding myself with the following person, agency or organization:

Attention:	
Name of Agency or Organization :	
Telephone Number:	
Fax Number:	
Address, City, Province, Postal Code:	

Information Requested:

Signature of Client/Patient

Date

Signature of Witness

Date

Name of Witness

(This form is effective for one year from the date listed**)**

