

# AUTHORIZATION AND CONSENT TO RELEASE OF INFORMATION

## *To Whom It May Concern:*

I, the undersigned consent and authorize the release of information contained in **any health records (including hospital records, physician office records, pharmaceutical prescription records and patient billing information)** concerning the patient (s)

**Print Full Name of Patient (s)** \_\_\_\_\_

**Patient's Health Card # ('s)** \_\_\_\_\_

**Patient's Date of Birth (s)** \_\_\_\_\_

**Print Full Name of Person Making Complaint** \_\_\_\_\_

to the College of Physicians and Surgeons of Nova Scotia. This will also provide consent for the College of Physicians & Surgeons of Nova Scotia to request, receive, photocopy and disseminate this information as necessary for the investigation of the above complaint in accordance with the disciplinary process.

*If the complainant is someone other than the patient or the patient's legally authorized representative, complete the following:*

*I hereby authorize \_\_\_\_\_ to pursue this complaint*  
(Print complainant's name)  
*on my behalf and to receive all information in relation to the investigation of the complaint.*

*If you are filing this complaint on behalf of the patient, please provide a copy of the documentation authorizing the complaint. Examples include: executor of an estate, legal guardian, next of kin, patient's written consent, etc.*

\_\_\_\_\_  
**Patient's Signature**

**OR**

***Legally authorized Representative\****

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
**Relationship to patient (please state)**  
(\* includes: executor or administrator of an estate, next of kin or legal guardian)

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Witness (print)**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
**Phone Number**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date**