**Authorization for Release of Information**

Name:

Date of Birth:

Address:

City:

Province:

Postal Code:

Phone Number:

Email:

|  |  |
| --- | --- |
| I authorize Epilepsy South Eastern Ontario to release information to: | I authorize Epilepsy South Eastern Ontario to obtain information from |
| **Organization Name:** | **Organization Name:** |
|  |  |
| **Address:** | **Address:** |
|  |  |
|  |  |
| **Postal Code:** | **Postal Code:** |
|  |  |
|  |  |
|  |  |

**Specific Information Authorized:**

**------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------**

**I understand that:**

1. I do not have to sign this authorization and my refusal to sign will not affect my ability to obtain services.
2. I may cancel this authorization at any time by submitting a written request to Epilepsy South Eastern Ontario, except where disclosure has already been made in reliance of my prior authorization.

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Signature

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

Relationship to the client if signing on the client’s behalf

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

Witness

Date: