



AUTHORIZATION FOR RELEASE OF INFORMATION Confidential Medical and Personal Care

I hereby authorize _____
Name of facility/agency releasing information

And the TBI Integration Project to release information from the Client Records to the following facilities/agencies/provider(s):

Name of facility/agency/provider

Name of facility/agency/provider

Name of facility/agency/provider

I understand that this information is to be used by the recipient(s) for the purpose of data gathering and to facilitate referral.

Expiration Date of Authorization: 2002/09/15

Client/Substitute Decision Maker:

print name

signature

Date: (Y)____/(M)____/(D)_____

Relationship if signed by other than the client: _____

Witness:

print name

signature

Date: (Y)____/(M)____/(D)_____

This form is to be kept by the referring Service Provider in the client's records
A copy of this form needs to be sent to the TBI Project's Clinical Coordinator.

Project Information:

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