EM/ANB Inc.

Authorization to Release Information *(v.2, 2019)*

Note: Your information is protected in accordance with the New Brunswick *Right to Information and Protection of Privacy Act* as well as the New Brunswick *Personal Health Information Privacy and Access Act.* If you have any questions about this form or how your information is protected, please contact EM/ANB's Privacy Office at 506-872-6594.

By completing and signing this form you authorize the sharing of your personal information and/or personal health information in the manner described below. You may revoke this authorization at any time by contacting EM/ANB's Privacy Office.

I, _____ (print full name), of _____

_____ (print address), hereby authorize _____ (name of person or information custodian) to release my personal information and/or personal health information to _____ (print name/title of person or organization to whom the information may be released).

Please specify the parameters of the information to be shared with the person(s) named above (check one, and fill in the blanks):

☐ All information in my name held by _____ (name of person or information custodian named above)

☐ Only information held in my name from _____(date) to _____ (date)

☐ Only information related to _____ (specify incident/ treatment/ service)

☐ Other (please specify):

_____ _____

Signature Date

_____ _____

Witness Date

The authorization provided by this form will remain in effect unless revoked. If you wish to revoke the authorization, please contact EM/ANB's Privacy Office at 506-872-6594.

Administrative Use Only

Received by: _____

Date: _____