



EM/ANB Inc.

Authorization to Release Personal Health Information (version 1.1, 2018)

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 EM/ANB Inc. to share your personal information and personal health information with the person you name 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 EM/ANB Inc. to release my personal
information and personal health information to _____
_____ (print name/title of person 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 if applicable):

- All information in my name held by EM/ANB Inc.
- Only information held by EM/ANB Inc. in my name from _____ (date) to _____ (date)
- Only information related to _____ (specify incident/treatment)

Signature

Date

Witness

Date

The authorization provided by this form will remain in effect for 90 days from the date signed. If you wish to revoke the authorization prior to that date, please contact EM/ANB's Privacy Office at 506-872-6594.

Administrative Use Only

Received by: _____

Date: _____