St. John Ambulance

RELEASE OF ST. JOHN AMBULANCE PATIENT CARE RECORD

To: Provincial Commissioner
St. John Council for Ontario
46 Wellesley Street East
Toronto, Ontario
M4Y 1G5

Re: _____
(name of patient)

_____
(date of birth)

_____
(date and place of incident - please include name of event)

I do hereby authorize and direct you to release to

_____ copies of all
(name of person/agent/representative Patient Care Record will be released to)

documents in your possession pertaining to my treatment on the above date, including the Patient Care Records. I further release the St. John Council for Ontario, its employees, members and agents from any and all actions, causes of action and claims for damages, however arising which may be sustained by me as a result of the delivery of any documents in your possession concerning me including Patient Care Records.

Dated at_____(town/city) this_____(day of month) day of_____(month), _____(year).

_____
(Witness's signature)

_____
(Witness's name - please print)

_____
(Patient's signature)

_____
(Patient's name - please print)

_____
(Patient's address)

_____
(Patient's phone number)

REV.: 13/09/00