08/03/2021

LETTER OF AUTHORIZATION FOR RELEASE OF INFORMATION

I, ________________________________(Name of client or holder of client's Power of Attorney), hereby authorize the following institutions and agencies

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(Name of institutions or agencies)

to release to OPEN ARMS PATIENT ADVOCACY SOCIETY, their advocates or delegate, any and all information related to the following (describe particulars of medical situation, including approximate timeline and about whom the incident occurred):

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____________________ Date_________Print Name____________________

(Signature of client)

Address of Client:

____

____

Open Arms Patient Advocacy Society

PO Box 16075, RPO
Lower Mount Royal,
Calgary, Alberta T2T 1A0

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F. 403-548-3343
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