Medical Release Authorization

I authorize my attending Physician/Nurse Practitioner and/or my caregiver to release any medical information to St. John's Centre.

I understand that:

1. This information is required to complete the application process for a unit at St. John's Centre.
2. This information will be kept in strict confidence.
3. This information will be retained on my file at St. John's Centre.

Name of Physician/Nurse Practitioner: _____

Telephone Number:_____
Address: _____

_____

The applicant is responsible for any fees incurred for the completion of any medical forms.

_____ _____
Applicant Name (Please Print) Applicant Signature

Dated on this _____day of _____, _____.