AUTHORIZATION FOR
RELEASE OF MEDICAL INFORMATION

TO WHOM IT MAY CONCERN:

NAME: ____________________ **(Name)**

DOB: ____________________

HSN: ____________________

I,______________________________ (name), _________________ (mother/father) of ________________________ (child's name), hereby request and give you a full authority and direction to release to CUELENAERE, KENDALL, KATZMAN & WATSON, #500, 128 Fourth Avenue South, Saskatoon, SK S7K 1M8, any and all information, including copies of all hospital records, medical records, X-rays, Angiograms and Diagnostic Radiology Records and any other such records maintained by you in relation to treatment received by ______________________ (child's name) at your Hospital/Clinic. Such authorization will also allow copies of records, X-rays, Angiograms and Diagnostic Radiology Records to be made at the request and authorization of CUELENAERE, KENDALL, KATZMAN & WATSON for the purpose of ongoing litigation.

This authority shall continue in force until expressly revoked by me in writing.

DATED at _____________, Saskatchewan, this _____ day of _______________, A.D. 2017.

____
Witness

____
Printed Name

____
Signature of Guardian