IWK Authorization for Release of Health Information

I do hereby give my consent to the IWK Health Centre to release **Mental Health Assessments, Mental Health Reports, Mental Health Treatments, and Mental Health Medications** regarding:

Name of Patient Date of Birth (day/month/year)

To: Nova Scotia Health Authority
Nova Scotia Mental Health Court Program
Suite 203, 277 Pleasant Street, Dartmouth, Nova Scotia, B2Y 4B7
Phone: (902) 722-1040 Fax: (902) 428-2158

For the purpose of **Nova Scotia Mental Health Court Program Screen Report**.

Signature of Person Giving Authorization Date

Address

Telephone Number

Relationship to Patient: ☐ Self ☐ Legal Guardian

Witness: _____

IWK Health Centre
Release of Information
5850/5980 University Ave.
PO Box 9700
Halifax, NS B3K 6R8 Canada
Tel: 902.470.8888
Fax: 902.470.8851
www.iwk.nshealth.ca