ExamOne®
A Quest Diagnostics Subsidiary

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I, _____ hereby authorize:
(Print Name)

_____

_____
(Name of Facility)

To release the following information:

To be released to:

_____ c/o ExamOne Insurance
100 International Blvd., Toronto, ON, M9W 6J6

from the records of:

NAME: _____ DOB: _____

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

PHONE: _____

I consent to the use of information only for the purpose of:

_____ _____
Date Signature of Patient/Authorized Representative

_____
Legal Representative's Relationship to Applicant

_____
Witness Signature