



Name [redacted] Facility H.R.C. Casebook No. [redacted] Ward or Unit Out 10

You are hereby authorized to release to/or obtain from CHRISTIAN HORIZONS
Name of facility, agency, physician, etc.

any information from my records, in accordance with the policy of the facility, as may be necessary or desirable for my care
or treatment.

Date APRIL 7/97

Date _____

Witness [redacted]

Signature of Resident _____

Address of Witness [redacted] H.R.C.

Relationship - If other than Resident _____

*AUTHORIZATION RECEIVED BY TELEPHONE
FROM [redacted] (SISTER) ON APRIL 7 1997.*

* AUTHORIZATION must be signed by the resident, or in the case of a minor by the parent or legal guardian
whichever is the appropriate legal authority. In the case of a person who is physically or mentally disabled to
such a degree as to be incapable to give consent, the next-of-kin may authorize release of information.



Name [Redacted] Facility H.R.C. Ward or Unit Cot 8.
ORILLIA.

Casebook No. [Redacted]

You are hereby authorized to release to/or obtain from CHRISTIAN HORIZONS.
Name of facility, agency, physician, etc.
STOUTVILLE

any information from my records, in accordance with the policy of the facility, as may be necessary or desirable for my care or treatment.

Date June 25/97.

Date 6-25-97

[Redacted Signature]

[Redacted Signature]
Signature of Resident

Social Worker - H.R.C.
Address of Witness

PARENT.
Relationship - If other than Resident

*AUTHORIZATION must be signed by the resident, or in the case of a minor by the parent or legal guardian whichever is the appropriate legal authority. In the case of a person who is physically or mentally disabled to such a degree as to be incapable to give consent, the next-of-kin may authorize release of information.