Health Registries Authorization Form

Eligible Person

First Name _____

Middle Name _____

Last Name _____

Relationship to Person Named on Certificate / Health Card _____

Street Address _____

City _____

Province _____

Postal Code _____

Phone Number _____

Authorized Individual

First Name _____

Middle Name _____

Last Name Relationship _____

to Eligible Person _____

Organization Name _____

Street Address _____

City _____

Province _____

Postal Code _____

Phone Number _____

Document Requested

Birth

☐ Certificate

☐ Certified Copy

Death

☐ Certificate

☐ Certified Copy

Marriage

☐ Certificate

☐ Certified Copy

Health Card

☐ Health Card

I hereby waive, for the purpose of such document, any privilege I may have regarding secrecy of information and release and discharge eHealth Saskatchewan to whom this release may be directed of all claims for any damages I may sustain resulting from any such report given to the above-named party.

I FURTHER DECLARE that a photocopy of this Authorization shall be of the same force and effect as an originally signed copy.

Dated at _____ in the Province of _____ this _____ day of _____, 20_____.

_____
Signature of Eligible Person