



St. John Ambulance

## RELEASE OF ST. JOHN AMBULANCE PATIENT CARE RECORD

**To: Director, Standards and Support  
St. John Ambulance, Council for Ontario  
15 Toronto Street, Suite 800  
Toronto, Ontario  
M5C 2E3**

**Re:** \_\_\_\_\_  
(name of patient)  
  
\_\_\_\_\_  
(date of birth)  
  
\_\_\_\_\_  
(name of event where incident occurred)      \_\_\_\_\_  
(place of incident)  
  
\_\_\_\_\_  
(date of incident)

**I do hereby authorize and direct you to release to**

\_\_\_\_\_ copies of all  
(name of person/agent/representative Patient Care Record will be released to)

documents in your possession pertaining to my treatment on the above date, including the Patient Care Records. I further release the St. John Council for Ontario, its employees, members and agents from any and all actions, causes of action and claims for damages, however arising which may be sustained by me as a result of the delivery of any documents in your possession concerning me including Patient Care Records.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_  
(municipality) (day of month) (month) (year)

\_\_\_\_\_  
(Witness's signature)

\_\_\_\_\_  
(Patient's signature)

\_\_\_\_\_  
(Witness's name - please print)

\_\_\_\_\_  
(Patient's name - please print)

\_\_\_\_\_  
(Patient's full address, including postal code)

\_\_\_\_\_  
(Patient's phone number)