AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION
TO UNIVERSITY OF TORONTO HEALTH & WELLNESS CENTRE

To: ____________________________________________________________________________________
______________________________________________________________________________________

Telephone: __________________ Fax: __________________

RE: ___

PLACE LABEL HERE

The above named patient is under our care at the present time, and has requested that you transfer information from their health records to us. Below is the necessary written authorization for this release.

I hereby authorize the release of information from the health records of the above-named to:

Attention: Dr. ____________________________________________

(*Indicate the Name of Doctor at U of T Health & Wellness Centre)

Health & Wellness Centre, University of Toronto
Koffler Student Services Centre, Suite #232
214 College Street, Toronto, ON M5T 2Z9
Tel: 416-978-8034 Fax (Circle one): 2nd Floor: 416-971-2089 1st Floor: 416-978-7341

The information requested to be released is:

Clinical Notes ______ Lab Reports ______ Letters ______ Test Results ______
Summary ______ Other _______________________________________________________

*Any costs for this are at the expense of the patient. This release is valid for six months from the date of request.

I hereby waive any and all claims against the said Health and Wellness Centre, its physicians, employees and agents for all purposes whatsoever in connection with the said communication and disclosure of information in the said record.

This information must contain the original signature of the patient, or the legal representative if the patient is deceased or has been declared mentally incompetent provided proof of executorship is supplied.

Signature: ________________________________ Witness Signature: ________________________

Print Name: ________________________________ Print Name: ________________________________

Date: ______________________ (DD/MM/YYYY) Relationship to patient: ______________________

Date: ______________________ (DD/MM/YYYY)