UNIVERSITY OF TORONTO

HEALTH & WELLNESS CENTRE
MEDICAL RELEASE FORM
(Release of Health Record **FROM** Health & Wellness Centre)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FROM HEALTH & WELLNESS CENTRE

Re: _____ _____
Patient's Last name, First name **Date of Birth (DD/MM/YYYY)**

Student Number: _____ **Phone No**: _____

I hereby authorize the Health & Wellness Centre, University of Toronto, to release the information specified below to:

_____
Name of Health Care Provider or Student / Patient

_____
Address **Phone No:** **Fax:**

The information requested* to be released is:

Clinical Notes _____ Lab Reports _____ Letters _____ Test results _____

Summary _____ Other _____

I hereby waive any and all claims against the said Health & 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: _____

Print Name: _____

Date: _____
(DD/MM/YYYY)

Witness Signature: _____

Print Name: _____

Relationship to patient: _____

Date: _____
(DD/MM/YYYY)

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