UNIVERSITY OF TORONTO

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

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
700 Bay Street, 14th Floor
Toronto, ON M5G 1Z6
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: _____

Print Name: _____

Date: _____
(DD/MM/YYYY)

Witness Signature: _____

Print Name: _____

Relationship to patient: _____

Date: _____
(DD/MM/YYYY)