UNIVERSITY OF TORONTO

HEALTH & WELLNESS CENTRE, UTSG

MEDICAL RELEASE FORM

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

FROM HEALTH & WELLNESS CENTRE, St. George Campus (UTSG)

Email Completed form to: Info.HWC@utoronto.ca, Subject line: Medical Records Request

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

Student No: _____ **Phone No**: _____ **Email: _____**

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

_____
Student / Patient or Name of Health Care Provider

_____
Address

_____
Email **Phone No** **Fax No**

Select One of more below: By requesting specific types of records, you will likely receive them sooner.

- ☐ Records from **Mental Health Services**: including clinical notes from Psychiatrist, Psychologist, Social Worker, Psychotherapist, and Mental Health Nurse
- ☐ Records from **Medical Services**: including clinical notes from Family Physician, Nurse and Dietitian; and may also include information about your mental health care from Family Physician and Nurse
- ☐ **ONLY** Immunization Records
- ☐ **ONLY** Records from the following Provider(s), specify their name(s)
  _____
- ☐ **OTHER**, please provide details:
  _____

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: _____ **Witness Signature: _____**

Print Name: _____ **Print Name: _____**

Date: _____ **Relationship to patient: _____**
(DD/MM/YYYY)

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.