UNIVERSITY OF TORONTO SCARBOROUGH | Health & Wellness Centre

Consent to Release or Obtain Personal Health Information

Patient Name _____ Patient Date of Birth (YYYY/MM/DD) _____

Student Number _____ Telephone Number _____ Email _____

I hereby authorize the University of Toronto Scarborough Health & Wellness Centre to

- ☐ Release the information specified below to:
- ☐ Obtain the information specified below from:

Name of Recipient (e.g., student, health care provider, legal office) or Requestee (e.g., previous health care provider) of the Records _____

Address _____

Email _____ Telephone Number _____ Fax Number _____

Select one or more of the following options:

- ☐ Records from Counselling Services
- ☐ Records from Medical Services (including clinical notes from a family doctor, lab results, consultation reports)
- ☐ Records from a Psychiatrist and/or Mental Health Nurse
- ☐ Records from a specific provider(s), please specify: _____
- ☐ Immunization/vaccination record
- ☐ Lab test results, please specify date(s) or type(s) of test: _____
- ☐ Diagnostic imaging results, please specify date(s) or type(s) of test: _____
- ☐ Other: _____

Date(s) of requested records (please be as specific as possible): From _____ To _____

If the Health & Wellness Centre needs to contact you regarding this request, the preferred method of communication is:

☐ By telephone to the number listed above ☐ By email to the email address listed above ☐ Other: _____

I understand the purpose for disclosing this personal health information. I understand that I can refuse to sign this form. I understand this authorization may be withdrawn at any time.

Patient Signature _____ Witness Signature _____

Print Name _____ Print Name _____

Date (YYYY/MM/DD) _____ Relationship to Patient _____

Date (YYYY/MM/DD) _____

Please note there may be a cost associated with the transfer of records. This release is valid 6 months from the date of request.

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