UNIVERSITY OF TORONTO

STUDENT LIFE | Health & Wellness

HEALTH & WELLNESS CENTRE I UTSG

MEDICAL RELEASE FORM

TO Health & Wellness Centre

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

TO **HEALTH & WELLNESS CENTRE, UNIVERSITY OF TORONTO, ST. GEORGE CAMPUS**

To: _____
(Name of Clinician/Clinic)

Telephone: _____ **Fax:** _____ **Email:** _____

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

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

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: _____
(*Indicate the Name of the Healthcare Provider at U of T Health & Wellness Centre (e.g. physician, psychiatrist)

☐ **HEALTH & WELLNESS CENTRE- Medical Services**
University of Toronto, St. George Campus
700 Bay Street, 14th Floor, Toronto, ON M5G 1Z6
t:416.978.8030 I f:416.971.2089

☐ **HEALTH & WELLNESS CENTRE- Mental Health Services**
University of Toronto, St. George Campus
700 Bay Street, 12th Floor, Toronto, ON M5G 1Z6
t: 416.978.8030 x.5 I f:416.978.7341

The information requested to be released is: ☐ Clinical Notes ☐ Lab/Diagnostic Reports ☐ Medication History

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.

Print Patient Name: _____ **Patient's Signature:** _____

Date: _____
(DD/MM/YYYY)

***Any costs for this request are the responsibility of the patient.** v.04.04.25