Student Wellness & Counselling Centre

FAX: 709-864-2087

Date: ____________________

Patient Name:____

Address: ____

____

MCP: ____

I authorize and request ____of the Student Health Service, Memorial University of Newfoundland, to release my medical records to:

____

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____

____

Date: ______________________________________Signature:___________________________

Date: ______________________________________Witness:_____________________________

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