



Student Wellness & Counselling Centre

Access to Information and Protection of Privacy – The information on this form is disclosed in accordance with the Personal Health Information Act (SNL 2008 p-7.01). The information collected on this form will be used for processing your request for disclosure of personal health information. For any questions about the collection and disclosure of personal information, please email [swcc.frontdesk@mun.ca](mailto:swcc.frontdesk@mun.ca)

**AUTHORIZATION FOR DISCLOSURE OF PERSONAL HEALTH INFORMATION**  
**Pursuant to the Personal Health Information Act, SNL 2008 p-7.01**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last Name Given Name

Address: \_\_\_\_\_  
Street City Province Postal Code

Phone #: \_\_\_\_\_ Health Card #: \_\_\_\_\_ MUN Student #: \_\_\_\_\_

Counselling Records to be released:

- Entire Counselling Record
- Part Counselling Record-*Specify Record:* \_\_\_\_\_

Medical Records to be released:

- Entire Medical Record
- Part Medical Record-*Specify Record:* \_\_\_\_\_

To release to: Name and address of Person Receiving Information

- Self
- Lawyer
- Insurance
- Care Provider
- Other: \_\_\_\_\_

Name: \_\_\_\_\_  
Last Name Given Name

Address: \_\_\_\_\_  
Street City Province Postal Code

Contact #: \_\_\_\_\_  
Phone Fax Email

Print: Patient Name/Substitute Decision Maker Name

Signature and Relationship (if Substitute Decision Maker) SIGN HERE

Date (DD/MM/YYYY)

Print: Name of Approver

Signature of Approver SIGN HERE

Date (DD/MM/YYYY) **OFFICE USE ONLY**

This information is intended to be received only by the individual to whom it is addressed. This material contains confidential information. If you are not the intended recipient, you are notified that any dissemination, distribution or copying is prohibited. Please notify the sender immediately if you have received this material in error at the telephone number noted. Thank you for your cooperation.

This authorization will be valid for a three-month period as of the date of the signature unless specified otherwise.  
Withdrawal of Consent: This authorization may be withdrawn at any time, except with respect to actions already taken before the consent was withdrawn. Processing time is dependent on the volume of information requested.

5<sup>th</sup> Floor University Centre, UC-5000  
Memorial University of Newfoundland  
St. John's NL A1C 5S7

Tel: (709) 864-8500  
Fax: (709) 864-2087  
Email: [swcc.frontdesk@mun.ca](mailto:swcc.frontdesk@mun.ca)