Student Wellness Centre
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Waterloo, Ontario N2L 3C5
T 519.884.0710 x3146
F 519.340.1403
wellness@wlu.ca

Authorization for Release of Information

Pursuant to the Personal Health Information Protection Act, 2004 (PHIPA)

Please ensure this form is fully completed. Once you complete and sign this form, it authorizes the release of protected information.

Patient Information

Name: Health Card:
Laurier ID: Date of Birth:
Address: Laurier email:

Authorization

Patient hereby authorizes the Student Wellness Centre at Wilfrid Laurier University to

☐ Release information to
Address:
Phone: Fax:

☐ Request information from
Address:
Phone: Fax:

Release the Following Information

Please be as specific as possible about the information you would like released.

☐ Blood / test results dated
☐ Medical records. Please specify dates of visits or specific concern(s):

☐ Counselling records. Specify dates of visits:

☐ Other:

I hereby waive any and all claims against the physicians and staff of the Student Wellness Centre in connection with the disclosure of this personal health information.

X

Signature of Patient and Date

X

Signature of Witness and Date