ME First Wellness Professional Counselling

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606 33rd Street West, Saskatoon, SK., S7L 0W1

306-281-6674

AUTHORIZATION TO RELEASE/REQUEST HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth:_____

Previous Name: _____ SIN: _____

I request and authorize ME First Wellness to

[] release healthcare information of the patient to the following

[] obtain healthcare information of the patient from the following

Name: _____

Address: _____

City: _____Province:_____ Postal Code: _____

Phone Number: (___)_____ Fax Number: (___)_____

This request and authorization applies to:

[] Healthcare information relating to the following treatment, condition, or dates:

_____

_____

[] All healthcare information

[] Other:

_____

_____

[] Yes [] No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed:_____

ME First Counsellor Signature: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.