AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I am aware that The College of Physicians and Surgeons of Manitoba ("the College') is reviewing concerns about the care provided to me and that the College is collecting my personal health information for the purpose of its review.

You are hereby authorized to furnish and release to the College, or its representative, any and all information which it requests for the purpose of its review relative to my health, including my mental, physical or other condition, my health history, any prescriptions or any other treatment provided to me and the results of any diagnostic procedures.

I am aware that this authorization may be used by the College to:

- Request and receive such personal health information as physician office records/charts, hospital records/charts, prescribing information, and billing records.
- Photocopy and disseminate this information as necessary for the review of my care in accordance with the College's complaints process.

This authorization shall continue until revoked by me, in writing. A photostatic copy of this authorization shall serve in its stead.

Signed by me in the City/Town of _____, in the Province of Manitoba, this ____ day of _____ 201___.

_____ _____

WITNESS SIGNATURE

PRINT NAME

MB Health No. (6 digits): _____

Date of Birth: _____

Please Return Requested Information to:

Complaints/Investigation Department
College of Physicians and Surgeons of Manitoba
1000 – 1661 Portage Ave.
Winnipeg, Manitoba
R3J 3T7