McMaster University | STUDENT WELLNESS CENTRE

Student Wellness Centre
McMaster University, PGCLL, 210
1280 Main Street West
Hamilton, ON, L8S 4K1

905-525-9140 x 27700
1-855-683-4077
wellness@mcmaster.ca
wellness.mcmaster.ca

RELEASE OF PATIENT INFORMATION

PATIENT:	
Name (first-middle-last)	
Date of birth (YYYY-MM-DD)	
Student number	
Telephone number	
Mailing address	

RECORDS TO BE RELEASED:		
Name (person/institution/entity)		Student Wellness Centre
Telephone number		905-525-9140 x27700
Fax number		1-855-683-4077
Mailing address		McMaster University, PGCLL, 210, 1280 Main Street West, Hamilton, Ontario, L8S 4K1
	Entire medical (physician, psychiatrist, naturopathic doctor, nurse) record	
	Entire counselling (counsellor, social worker, psychologist, psychotherapist) record	
	Specific records	

PLEASE SEND THE ABOVE INDICATED PATIENT RECORDS TO:								
Name (person/institution/entity)								
Telephone number								
Fax number								
Mailing address								
Email address								
Preferred mode of transfer		Courier		Fax		Email (specific records only)		No preference

The transfer of records is considered an uninsured service. The patient is responsible for the $30.00 fee incurred for the transfer of an entire medical or counselling record. By signing this form, the patient understands that with only a few exceptions, they have the right to view and request copies of information in their record. Exceptions include the reasonable possibility of serious physical harm to the patient or someone else, and confidential information in the record about a person other than the patient. If the patient believes that information in their record is not accurate, they may submit a written request to correct the record. If the Student Wellness Centre (SWC) does not agree with the correction request, the patient may file a notice of disagreement into their record. The patient acknowledges and understands that SWC is not responsible for the security of their records after they have been released.

I (THE PATIENT) CONSENT TO THE RELEASE OF INFORMATION AS INDICATED ABOVE:	
Patient signature	
Witness signature	
Date (YYYY-MM-DD)	

If requested by SWC care provider or patient: I examined my records with a care provider in attendance, any questions or concerns presented were addressed.	
Patient signature	
Care provider signature	
Date (YYYY-MM-DD)	