THE UNIVERSITY OF BRITISH COLUMBIA

UBC Student Health Service
Student Development and Services

M334 – 2211 Wesbrook Mall
Vancouver, BC Canada V6T 1Z3
General Clinic: 604-822-7011
Psychiatry Clinic: 604-822-7689
Fax: 1-855-822-7212

students.ubc.ca/student-health-service

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Student Number: _____

Date of Birth: _____ Contact phone number in case of questions: _____
MM / DD / YYYY

I hereby authorize Student Health Service at UBC to release a copy of my medical record. I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. **I understand for administrative purposes, up to 30 business days may be required to complete this request.**

Requested Records (Choose ONE of the following):

- ☐ All Medical Records
- ☐ Other (Please Specify): _____

CHOOSE OPTION A OR B

A) Release to *SELF* (Choose ONE of the following):

- ☐ For pick-up
- ☐ Mail
- ☐ Fax: _____ **(Initials required)** I accept the risk of misdirected information via misdialed fax number and misdirected release within the receiving facility/company.
- ☐ Email: _____ **(Initials required)** I understand the privacy and security of email communication cannot be guaranteed. Please direct the ENCRYPTED records to the following email address: _____

B) Release to *PHYSICIAN or a THIRD PARTY:*

Name: _____

Address: _____ City: _____

Province/State: _____ Postal Code: _____ Phone Number: _____

Fax Number: _____

SIGNATURES REQUIRED

Signature of Patient: _____ Date Signed: _____

Signature of Witness (Required): _____ Name of Witness: _____

This consent will expire 1 year after the date this form is signed. If another expiry date is desired, please indicate new date below.

New expiry date if different from above: _____

OFFICE USE ONLY

When records are released to patient (self):

Reviewed by SHS Physician: _____ Date: _____