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 past and present 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 for release of such personal health information as physician office records/charts, hospital records/charts, prescribing information, and billing records.

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

Patient's MB Health No. (6 digits): _____

Patient's 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