Consent to Release or Obtain Health Information

Patient Name

Student Number　Telephone Number　Email

I hereby authorize the [illegible]

Release the information specified below to:

Obtain the information specified below from:

Name of Recipient [illegible] or Requestee (e.g., previous hea [illegible]

Address

Email　Telephone Number

Select one or more of the following options:

Records from Counselling Services

[illegible]

Records from a [illegible]

[illegible] – 1265 Military Trail | Toronto ON | M1C 1A4
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