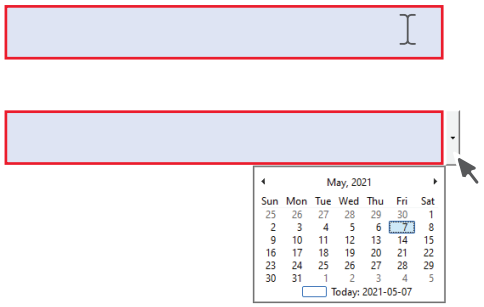
Authorization to Release Information

Please complete the following Authorization to Release information (see last page) and send your **FULLY** completed form by email to SHC@unb.ca.

HOW TO USE THE DIGITAL FORM:

1) Click any of the blue/red boxes on the form to type text, or click on the arrow to the right of the box to choose a date from the dropdown menu.

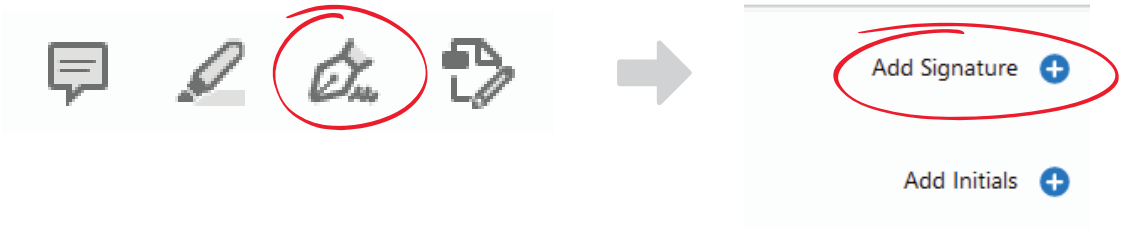


2) SIGNATURE REQUIRED - Please be sure to include your **signature** when submitting your consent form. There are 2 ways you can do this:

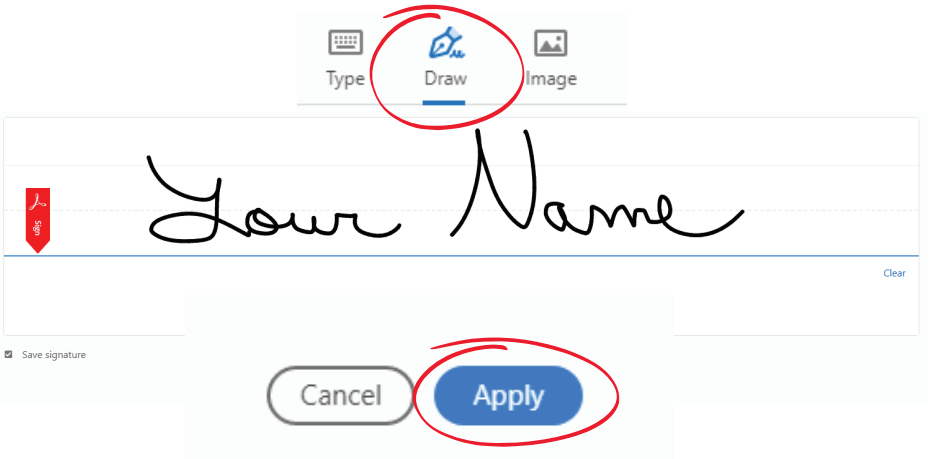
PRINT & COMPLETE THE FORM BY HAND: You can take a picture with your phone or scan the completed/signed form and submit by email.

DIGITALLY COMPLETE/SIGN THE FORM:

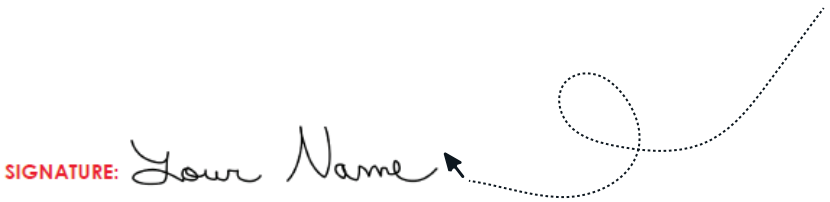
1) In Adobe Reader, click on the 'Sign Document' icon (top right), then click 'add signature'.



3) Be sure that you select ‘Draw’ at the top of the screen, and draw/sign your name using the computer mouse. When you are done click ‘Apply’.



3) Drag and drop your signature in the form by placing it where you want, then clicking the computer mouse.



4) Save and email your completed consent form.

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Dr. A. Martin
Dr. M. Piamonte
Dr. J. Smith
Stacey Taylor, NP

AUTHORIZATION TO RELEASE INFORMATION

I, _____ DOB: _____
(Full Name)

Student ID: _____ Healthcare/Medicare #: _____

GIVE PERMISSION TO: _____

TO RELEASE INFORMATION REGARDING MY MEDICAL CONDITION
(please specify information to be released):_____

_____

TO: _____

VIA: (*choose method below)*

- ☐ Fax (please provide number): _____
- ☐ Email (please provide email): _____
- ☐ Mail (please provide FULL address): _____
- ☐ In person pick-up *(please provide the name of person who will be picking up and instruct them to bring valid picture ID)*:_____

Please initial

_☐_ **I acknowledge and accept the privacy risks associated with faxing/emailing/mailing my personal health information, including (but not limited to) misdirected, disclosed or intercepted confidential/personal information. I acknowledge fax, email, and mail are not secure methods of transmission of information, but give permission to proceed with the method selected. I understand I can withdraw my consent at any time by emailing the Student Health Centre at SHC@unb.ca**.

STUDENT SIGNATURE:_____ **PRINTED NAME:**_____

DATE: _____