Consent for Disclosure of Personal Health Information

To: Manitoba Developmental Centre

Attn: Health Information Services Coordinator

PO Box 1190

Portage la Prairie MB R1N 3C6 Ph : (204)856-4203

You are hereby authorized to disclose to:

_____

(Name of Facility, Agency, Physician, etc.)

the following information:

_____

_____

(State what information is required and for what dates)

_____

(Full name and date of birth)

in accordance with the policy of the facility, and as may be necessary or desirable for the information or health care of the above-named.

This consent shall remain in effect until the ____ day of _____, 20___ (Not to exceed 1 year)

I understand that I can revoke or amend this consent in writing at any time before it expires. I declare that this consent has been given freely.

Date	Date
Signature of Witness	Signature
Print Name:	Print Name:
Address of Witness	Relationship, if other than resident

CR.36 (02/2018)