PCCMT PACIFIC COASTAL COLLEGE OF MASSAGE THERAPY
HEALTH & WELLNESS COLLEGES OF CANADA

Medical Release Form

Student's Name:_____Date of Birth: _____/_____/_____

Address: _____

City: _____ Province: _____ Postal code: _____ Phone: _____ Email: _____

Information Requested From:

Name: _____

Phone: _____ Email: _____

Send Information to:

Name: _____

Address: _____

City: _____ Province: _____ Postal code: _____

Phone: _____ Email: _____

I, _____ *(Name)*, hereby grant permission for PCCMT to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information, to the physician/person/facility/entity.

_____
Printed Name Date

_____
Signature Date