Department of Health and Community Services
Newfoundland and Labrador Prescription Drug Program

NEWFOUNDLAND AND LABRADOR PRESCRIPTION DRUG PROGRAM RELEASE OF PERSONAL INFORMATION CONSENT FORM

1. I,_____ hereby give my informed consent to the
(client name as it appears on MCP card)
Pharmaceutical Services Division of the Department of Health and Community Services and its service provider to disclose any or all of my personal health information in its possession to_____ my _____
(insert individual or organization name) (son, daughter, husband, caregiver, etc)
for the purpose of enabling or assisting me to receive health care benefits under the Newfoundland and Labrador Prescription Drug Program.

2. This consent survives until terminated or withdrawn, in writing by me.

_____ _____
Client Signature Witness Signature

_____
Witness Name (Please print)

Dated at _____, this ____ day of _____, _____.
(Community) (Day) (Month) (Year)

_____ _____
Client MCP Number Address

_____ _____
Social Insurance Number City

_____ _____
Date of Birth Telephone Number

Upon completion, return to the address below or fax to: 709-729-2851. For questions or concerns please call: 709-729-6507 or toll free at: 1-888-222-0533.

Newfoundland and Labrador Prescription Drug Program
Department of Health and Community Services
P.O. Box 8700, St. John's, NL A1B 4J6