

Request for Release of Beneficiary MCP Number

Section 1 PATIENT'S PERSONAL INFORMATION

Surname		Given Name and Initials	
Maiden Name (if applicable)		Gender – M/F	Birth Date – Year/Month/Day
P.O. Box/Street Address			
City/Town	Province	Postal Code	Phone Number
<p>I agree to allow the Department of Health and Community Services to release my MCP Number to the health care Provider/Facility shown below.</p> <p>_____ Date _____</p> <p>Signature of Patient or Guardian</p> <p>A parent or guardian may sign for a child under 16 years of age. A person holding power of attorney may sign for the represented individual.</p>			

Section 2 PROVIDER/FACILITY

Provider Billing Number	Facility Number
Provider Name, Address, and Telephone Number	Facility Name, Address, and Telephone Number
_____	_____
Signature of Provider or Designate	Signature of Authorized Facility Employee
_____	_____
Date	Date

Section 3 FOR MCP USE ONLY

Patient's MCP Number and Expiry Date(MM/DD/YYYY)
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