



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

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- This consent survives until terminated or withdrawn, in writing by me.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