

# Authorization for release of medical information

To complete this form, **you need to download this form first** and fill it out using free Adobe Reader software. You will need to send it back to [hrc.cdp@gnb.ca](mailto:hrc.cdp@gnb.ca).

Name	
Date of Birth	
Medicare Number	

I hereby authorize, by this document or photocopy thereof, any physician, specialist, hospital, clinic, employer or other institution where I was treated or examined to disclose or provide to the New Brunswick Human Rights Commission, any information, diagnosis or prognosis including x-rays, documents or other related material, relating to my state of health.

I also authorize the New Brunswick Human Rights Commission to inquire into the history of my association with any physician, specialist, hospital, clinic, employer or other institution where I was treated or examined by interview or questionnaire and to acquire any related documents.

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Signature

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Date (YYYY/MM/DD)