



# Authorization for Release of Information (Birth Records)

633 Wellington Crescent  
Winnipeg, MB R3M 0A8, Canada  
Telephone: (204) 235-8866 Fax: (204) 235-8870

I, \_\_\_\_\_ hereby authorize and direct  
(Legal Guardian/Parent)  
\_\_\_\_\_ to forward medical information regarding birth history/records received by:  
(Hospital)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

MHSC#: \_\_\_\_\_ PHIN #: \_\_\_\_\_  
(or alternate Health Care #)

Address: \_\_\_\_\_

Birth Mother: \_\_\_\_\_ DOB: \_\_\_\_\_

Birth Father: \_\_\_\_\_ DOB: \_\_\_\_\_

This information may be released to the  
**Manitoba FASD Centre**  
**633 Wellington Crescent**  
**Winnipeg, MB R3M 0A8**  
(For medical assessment purposes)

The \_\_\_\_\_ is hereby released from all legal liability that may arise from  
(Hospital)

the release of the information requested.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Witness: \_\_\_\_\_

Print Name: \_\_\_\_\_