

IN THE MATTER of the *Medical Profession Act* of the Yukon
and in the matter of a complaint regarding the conduct
and medical care given by _____ ,
physician(s) licensed and practicing medicine in the Yukon.

CONSENT TO RELEASE OF INFORMATION

I, _____, of _____, Yukon,
(Name of Complainant) (Community)
Yukon Health Care Insurance # _____, and
Date of Birth _____, HEREBY authorize the Registrar of
Medical Practitioners, the Yukon Medical Council, or their representative, to
obtain a copy(ies) of my medical records and/or any other information which
may be required in the investigation of my complaint against
_____, registered in the Yukon Medical Register and
licensed to practise medicine in the Yukon. The Registrar has my authorization
to use photocopies of this consent.

Date

Signature of Complainant

Date

Signature of Witness

Please print name and address of witness