MTG HEALTHCARE ACADEMY

AUTHORIZATION FOR THE RELEASE OF PERSONAL INFORMATION

The use of this form is to authorize MTG Healthcare Academy to release your personal information with your specific needs.

Note: MTG Healthcare Academy will not authorize the release of your personal information, except as required by law, without your explicit written consent.

Personal information to be released (please check appropriate boxes):

- ☐ Name
- ☐ Student Number
- ☐ Contact information (i.e. permanent mailing address, telephone #, e-mail address)
- ☐ Financial information (i.e. records of payment, non-payment & falsified payment)
- ☐ Academic information (i.e. course schedules, grades, attendance records)

This personal information may be released to

☐ Designated Individual:

Name _____

Mailing Address _____

Telephone Number _____

Relationship to requesting person _____

☐ Potential Employers (calling to confirm attendance, check references etc.)

☐ Other (please specify) _____

This consent is valid for duration of six months from _____

I may revoke my consent at any time by notifying the MTG Health care Academy in writing that consent has been withdrawn.

By my signature, I hereby consent to the release of my personal information in accordance with the specifications detailed on this consent form.

_____ _____

Student Name Date

_____ _____

Student Signature ID #

Our Locations

Calgary Campus

403 264 2009 | 403 992 7611
Fax: 587 352 2049

1324 36 Avenue NE
Calgary, Alberta | T2E 8S1

Red Deer Campus

403 264 2049 | 403 986 0684
Fax: 403 986 4815

4811 48 Street
Red Deer, Alberta | T4N 1S6

Edmonton Campus

780 863 8236
Fax: 780 434 8328

6920 Roper Road NW
Edmonton, Alberta | T6E 0A8

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