Government of Newfoundland and Labrador
Department of Health and Community Services

Request for Release of Beneficiary MCP Number

Section 1	**PATIENT'S PERSONAL INFORMATION**		
Surname		Given Name and Initials	
Maiden Name (if applicable)	Gender – M/F	Birth Date – Year/Month/Day	
P.O. Box/Street Address			
City/Town	Province	Postal Code	Phone Number

I agree to allow the Newfoundland and Labrador Medical Care Commission to release my MCP Number to the health care provider/facility show below.

_____ _____
Signature of Patient or Guardian Date

A parent or guardian may sign for a child under 16 years of age. A person holding power of attorney may sign for the represented individual.

Section 2	**PROVIDER/FACILITY**
Provider Billing Number	Facility Number
Provider Name, Address, and Telephone Number	Facility Name, Address, and Telephone Number

_____ _____
Signature of Provider or Designate Signature of Authorized Facility Employee

_____ _____
Date Date

Section 3	FOR MCP USE ONLY
	Patient's MCP Number

http:/www.gov.nl.ca/mcp

P.O. Box 5000, Grand Falls-Windsor, NL, Canada, A2A 2Y4 t 1.800.563.1557 f 709.292.4052