Physicians Working Together
for Better Health Care

Medical Records Release Form

I ____ ____
(Patient Name, incl. Maiden Name if applicable – First, Last) (Date of Birth – dd/mm/yr)

____ ____
(Street Address) (City, Province, Postal Code)

____ ____
(Telephone #'s) (Health Card #)

Hereby authorize:

____ ____
(Name of former Physician) (Name of Health Care Facility)

____ ____
(Street address) (City, Province, Postal Code)

____ ____
(Telephone #) (Fax #)

To release my medical records to:

____ ____
(Name of new Physician) (Name of Health Care Facility)

____ ____
(Street address) (City, Province, Postal Code)

____ ____
(Telephone #) (Fax #)

I authorize release of my medical records in accordance with the specifications listed above. I understand written notice is necessary to cancel this request.

I understand there is an administrative fee of $45.00 to cover the costs of compiling, copying, couriering, and archiving the charts. We do our best to expedite uncomplicated record transfers.

We thank you in advance for you assistance.

Signature: ___________________________________ **Date**: ______________________________________

If **signed by person(s) other than the noted patient above, state the relationship and authorization to do so:**

Patient is: ☐ Minor ☐ Incompetent ☐ Disabled ☐ Deceased ☐ Other: _______________

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