Vancouver Family Practice Centre
402- 750 W Broadway
Vancouver, BC Canada V6Z 1H3
Tel: 604-829-2570 I Fax: 604-398-6405

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS INFORMATION

Patient Name: _____ Date of Birth: _____
MMM/DD/YYYY

Personal Health Number (PHN) _____ Phone Number: _____

I hereby authorize Vancouver Family Practice Centre to release a copy of my medical record. I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance of this consent. I understand for administrative purposes, it may require up to 30 business days to complete this request.

I understand that this service/request is not recognized as "medically required" and is not covered by medical plan. I realize that there may be a charge for this service/request.

Choose one of the following

☐ A. Release to self:
☐ All medical records
☐ Specific records (Please specify): _____
_____

How would you like to receive your records?
☐ CD (password protected)
☐ Patient Portal
☐ Email (password protected): _____
☐ Fax: (Please provide fax number): _____
☐ Mail: (Please provide mailing address): _____
_____

☐ B. Release to a PHYSICIAN or a THIRD PARTY (insurance, lawyers, employers etc)

Name: _____

Address: _____
(City) (Province) (Postal Code)

Phone Number: _____

Fax Number: _____

Signature of Patient: _____ Date Signed: _____

Name of Witness: _____ Date Signed: _____

Signature of Witness: _____

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Office use only:
Date received:_____ Staff initial: _____
Date reviewed: _____ Reviewed by VFPC Physician: _____