Vancouver Family Practice Centre
Suite 301 West Tower
555 West 12th Ave
Vancouver, BC Canada V5Z 3X7
Tel: 604-210-0404 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 my medical plan. I realize that there may be a charge for this service/request.

Choose one of the following:

- ❑ ALL medical records
- ❑ Other (Please specify):

_____

Who are we releasing these records to?

→ **Release to SELF:**

- ❑ Patient Portal
- ❑ Email (<u>not</u> encrypted or password protected*)*
- ❑ Mail (please provide mailing address): _____

OR

→ **Release to a PHYSICIAN or a THIRD PARTY (insurance, lawyers, employers, etc.)**

Name of third party: _____

Address: _____

Phone Number: _____ Fax Number: _____

Email: _____

Signature of Patient: _____ Date Signed: _____

Name of Witness: _____

Signature of Witness: _____ Date Signed: _____