AUTHORIZATION TO OBTAIN MEDICAL RECORDS

(Please complete the form if you have seen specialist in the past)

I, _____, PHN _____,

DOB _____ hereby authorize Vancouver Family Practice to request a copy of my medical information from the following healthcare providers:

Dr. _____ Dr. _____

Phone:_____ Phone:_____

Fax : _____ Fax : _____

Dr. _____ Dr. _____

Phone:_____ Phone:_____

Fax : _____ Fax : _____

Information authorized to be released:

☐Entire Medical Chart ☐Other: _____

Please send the following information to:

VANCOUVER FAMILY PRACTICE
402-750 West Broadway
Vancouver BC Canada V6Z 1H3
Phone: 604-829-2570
Fax: 604-398-6405

Attention: _____
(Doctor Name)

Patient's signature: _____

Witness Name: _____

Date: _____