Patient Authorization for Release of Medical Records

Please fax form to (647) 344-3937

1. Patient (complete in full):

Name — Last, First, Middle		Health Card Number
Address		Date of Birth
City	Province	Postal Code
Home Phone	Cell Phone	Email

2. Records Released From:

Name	Dr. Andrea K. Leung				
Address	3447 Kennedy Road, Suite 207			Telephone	(416) 901-9100
City	Toronto	Province	Ontario	Postal Code	M1V 3S1

3. Records Released To:

Name — Last, First, Middle		
Address		Telephone
City	Province	Postal Code

I hereby authorize Dr. Andrea Leung to make all of my medical records and reports available to Dr:_____ located at _____.

I understand that if I wish to transfer my care to another physician, one FAXED copy of my records sent to my physician is free of charge.

I understand that copying, printing or digital reproduction of medical records will be subject to the standard Ontario Medical Association rate for uninsured services.

Signature of patient _____ Date _____

If not signed by the patient, please indicate relationship:
(Parent or guardian of minor patient, or guardian or conservator of an incompetent patient)

Name of Guardian/Representative _____

Legal Relationship _____

Date _____