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**PATIENT REQUEST FOR MEDICAL RECORDS TRANSFER
 AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

IMPORTANT:

If you moved from another province, please provide the healthcare number and address that your previous provider is familiar with.

PATIENT	Last Name		Address	
	First Name		City	Postal Code Province
	Healthcare Number	Sex	Date of Birth (yyyy-mm-dd)	Phone
	E-mail address (optional)			

PROVIDER	Clinic Name		Address	
	Provider Name		City	Postal Code Province
	Phone Number			
	Fax Number			

I have been a patient of your office/facility (or am the patient's authorized representative) and I understand that the facility/provider has legally protected health information about me (or the person I represent) that I wish to transfer.

I, _____, hereby authorize the provider above to release my records to Wesmed Medical.

Medical records to be released (please check all that apply):

- Entire Medical Record
- Radiology
- Other: _____
- Operative Records
- Outpatient/Clinic
- Lab Results

 Patient Signature

 Date

Please fax records to 778 646 2556.