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PATIENT REQUEST FOR MEDICAL RECORDS TRANSFER
AUTHORISATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION

PATIENT NAME

DATE OF BIRTH   HEALTHCARE NUMBER

ADDRESS   CITY   POSTAL CODE

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

PROVIDER THAT HAS YOUR RECORDS

I, ______________________________ hereby authorise the provider to release my records:

PROVIDER NAME

ADDRESS   CITY   POSTAL CODE

PHONE   FAX

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

❒ Entire Medical Record   ❒ Operative Records   ❒ Lab Results
❒ Radiology   ❒ Outpatient/Clinic
❒Other: ____

Patient Signature   Date

Please fax records to 778 646 2556.