University of Lethbridge

University of Lethbridge Health Centre

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CONSENT TO THE DISCLOSURE, TRANSMITTAL OR EXAMINATION OF A MEDICAL RECORD

I, _____ Birthday: _____
(Print Full Name)

Provincial Health Care Number: _____ Phone: _____

Hereby consent to the disclosure, transmittal or examination of information of my medical record, including reports, test results and any other related information for the purpose of continuation of my medical or psychiatric care:

Specifically: _____

From:

Name:_____ Location:_____

Phone Number:_____ Fax Number:_____

To:

Name:_____ Location:_____

Phone Number:_____ Fax Number:_____

_____ _____
Signature Witness

Dated the _____ day of _____, _____ (year)

The specific action requested above to be taken within 1 month of date above

The Patient requesting this information is responsible for charges involved in such transmittal of information. Please contact patient concerning the fee prior to record transmittal.

The client may rescind or amend this authorization in writing at any time prior to the expiry date, except where action has been taken in reliance on the authorization.

This consent will expire in six months following the date on which it was obtained.