University of Lethbridge Health Centre

SU020, 4401 University Drive W.
Lethbridge, AB T1K 3M4
Phone: 403-329-2484 Fax: 403-329-2466

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.

Please email completed form to **health.centre@uleth.ca**