



University of Lethbridge Health Centre

SU020, 4401 University Drive W

Lethbridge, AB, T1K 3M4

Phone: 403-329-2484 Fax: 403-329-2466

CONSENT TO RELEASE MEDICAL RECORDS

Patient Information

Name: _____

DOB: _____
(dd/mm/yyyy)

Health Care Number: _____

Phone: _____

Address: _____

Email: _____

Authorization

I authorize the release and/or request of my medical records for the purpose of continuing my care.

Specific records requested:

Send Records From

Provider: _____

Phone: _____

Fax: _____

Clinic: _____

City: _____

Prov: _____

Send Records To

Provider: _____

Phone: _____

Fax: _____

Clinic: _____

City: _____

Prov: _____

Patient Signature

Witness Name (Print)

Date: _____
(dd/mm/yyyy)

Witness Signature

Important Information:

*This request will be processed within 30 days of the date signed above

*Fees may apply for the preparation and transfer of records. The patient will be contacted prior to any charges

*This authorization may be withdrawn in writing at any time before the request action is completed

*This consent is valid for 6 months from the date signed

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