POLYCLINIC
FAMILY AND SPECIALTY MEDICINE

2 CHAMPAGNE DRIVE (CHAMPAGNE CENTRE) TORONTO M3J 2C5
TEL: 416-222-6160 FAX: 416-222-9604

AUTHORIZATION FOR TRANSFER OF MEDICAL RECORDS

Date: _____

Patient LAST NAME: _____ FIRST NAME: _____

Date of Birth (mm/dd/yyyy): _____OHIP #: _____

I, the above named patient, authorize the following health care providers and institutions (listed below) to release ALL my medical records to the Polyclinic Family and Specialty Medicine Facility.

_____ _____
(Patient signature) (Witness signature)

~~~~~~~~~~~~Office Use~~~~~~~~~~~~

Authorization for Release of Medical Records From: (Name of doctor and/or institution)

_____ (T): _____ (F): _____

_____ (T): _____ (F): _____

_____ (T): _____ (F): _____

The above named patient has requested medical assessment and treatment at the Polyclinic Family and Specialty Medicine Facility. We would be grateful if you would provide information and/or medical files which could help us with the future care of the patient. If you have any questions, please call the Polyclinic. Thank-you for your cooperation.

Please include the following:

[ ] Cumulative Patient Profile (past medical history, surgeries, medications, allergies)
[ ] Recent labs (past 3 years) and any other relevant older lab results (ie. for diagnostic value)
[ ] Immunization records
[ ] Imaging Reports
[ ] Specialist Consultant Reports
[ ] Other:

Dr. _____