CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name: ____

Date of Birth: ____

Personal Health Number (PHN): ______________________________

Primary Physician's Name: ___________________________________

Phone: ____________________

Fax: ____________________

Dear Dr. ____________________ ,

I, ____________________, consent to release the following medical records for the last two years to Dr. Jacques du Toit, and to Dr. Stuart Howard of Sunshine Coast Health Centre:

- ☐ Any and all types of records you have
- ☐ Doctor visit notes
- ☐ Lab reports
- ☐ Emergency room notes
- ☐ Clinical notes
- ☐ Doctors orders
- ☐ History & Physical
- ☐ Specialist Consultations
- ☐ Radiology Reports
- ☐ Other: ____________

Please fax records to:

Attention: Sunshine Coast Health Centre Nursing Department

Fax: 1.888.875.0511

Phone: 604.487.9050 ext 200

Client Signature: ____________________________

Date: ____________________________

Witness: ____________________________

Date: ____________________________