Sunshine Coast Health Centre
A Non 12-Step Program

VOLUNTARY CONSENT
for Release of 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

Fax: 1.888.875.0511

Phone: 604.487.9050

Client Signature: _____

Date: _____

Witness: _____

Date: _____

SUBMIT

I have read and agree to these terms.	
Initial:	**Date:**