CENTRO MEDICAL
MEDICAL AND SURGICAL CENTRE

4610 Main Street
Vancouver, BC
V5V 3R7
Tel: 604-559-9933
Fax: 604-559-9911

Authorization for Release of Medical Records

Date: _____

To: Dr. _____

Address: _____

Tel: _____ Fax: _____

Re: Name: _____

PHN: _____ Date of Birth (D/M/Y): _____/_____/_____

Re: Name (dependent): _____

PHN: _____ Date of Birth (D/M/Y): _____/_____/_____

Re: Name (dependent): _____

PHN: _____ Date of Birth (D/M/Y): _____/_____/_____

The above named patient(s) is/are now attending this clinic. It would be appreciated if you would forward to me a **SUMMARY** of the medical history and records, at your convenience. Thank you.

Please do **NOT** send the original chart.

Attending Physician: _____

I hereby authorize any physician, hospital or clinic to whom or where I have been observed or treated for any reason to give full particulars thereof, including prior medical history.

I understand there may be a charge in accordance with the BCMA fee schedule as the service is not covered by the Medical Services Plan.

Patient/Guardian Signature: _____

Patient/Guardian Name: _____