Authorization for Release of Medical Information

Last Name: First Name:

Date of Birth: Personal Health Number:

Address:

Contact number: Email:

**I authorize Kensington Medical Clinic to release my information to:**

Dr. Address:

Phone Number: Fax Number:

This request applies to: entire chart immunization records other results

Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The patient is aware that transfer of medical records is not an insured service and is aware of the $40 fee.**

***\*\*****Please note Kensington Medical Clinic is paperless, and electronic copies will be forwarded either by fax, email or provided on CD.*

**I hereby authorize the release of my medical records**

Patient signature: Date:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OFFICE USE ONLY**

Reviewed: Sent by: Date:

Fax: Email: CD: