KENSINGTON MEDICAL CLINIC

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P 604.299.9769 F 604.299.9772

kensingtonmedicalclinic.com

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: