Direction & Authorization for the Transfer of Medical Records

A. Information

1. Patient Name (complete in full):_____

2. Health Card Number:_____

3. Address:_____

4: Date of Birth:_____

5. City:_____ Province:_____ Postal Code”_____

6. Home Phone:_____ Cell:_____ Email:_____

B. Authorization

I hereby authorize Involved Medical Clinic to make all of my medical records and reports available to Dr. Eva Kovacs.

Signature of patient _____ Date _____

If not signed by the patient, please indicate relationship: (Parent or guardian of minor patient, or guardian or conservator of an incompetent patient)

Name of Guardian/Representative _____

Legal Relationship _____

Date _____ Witness _____