

Voluntary Consent for Release of 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 to support my short-term stay at Georgia Strait Women's Clinic:

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: Georgia Strait Women's Clinic

Fax: 1.604.487.9044

Phone: 1.866.487.9040 ext. 202

Client Signature: _____

Date: _____

Witness: _____

Date: _____

SUBMIT

I have read and agree to these terms.

Initial:

Date: