Georgia Strait
WOMENS CLINIC

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 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: