IMPERIAL MEDICAL CLINIC
4648 IMPERIAL ST, BURNABY, BC V5J 1B8
T: 604-409-8000 F: 604-409-4000
www.imperialmedicalclinic.ca

RELEASE OF MEDICAL RECORDS FORM

PROVIDER OR FACILITY RELEASING RECORDS

Provider/Facility Name: _____

Address: _____

Phone: _____ Fax: _____

PATIENT INFORMATION

Name: _____ Phone: _____

PHN: _____ Address: _____

DOB: _____ Email: _____

REQUESTED RECORDS (please specify date range if applicable)

☐ Labs: _____ ☐ Consultations: _____

☐ Imaging: _____ ☐ All Records: _____

☐ Other (please specify): _____

PURPOSE OF REQUEST

☐ Transferring care to a new family doctor or nurse practitioner

☐ For ongoing care with specialists, physiotherapists, naturopaths, or other healthcare providers

☐ Moving out of province

☐ Personal Use

☐ Other (please specify): _____

*For **insurance** and **legal purposes**, please have the third party fax their request along with your signed authorization to release medical information to our office at **604-409-4000**.*

RECIPIENT OF RECORDS

Please select one: ☐ Imperial Medical Clinic ☐ Myself (Patient) ☐ Other (complete below)

Recipient Name: _____

Address: _____

Phone: _____ Fax: _____

AUTHORIZATION

I understand that this service is not covered by MSP and I am responsible for any fees that may occur.

☐ I, the patient, hereby authorize the Provider/Facility to release the records requested to the named Recipient of Records.

☐ By signing below, I confirm that I have legal authority to act on behalf of the patient and I hereby authorize the Provider/Facility to release the requested records to the named Recipient of Records.

Relationship to Patient: _____

_____	_____	_____
Printed Name	Signature	Date Signed (YYYY-MM-DD)