Rocky Medical Clinic

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To: _____

Fax: _____

I am now attending ROCKY MEDICAL CLINIC for medical care. I would appreciate your sending, at your earliest convenience, medical information that may be in your possession. The specific information I require pertains to:

Patient name: _____

DOB: _____ PHN: _____

Phone numbers: _____

Mailing Address: _____

_____

Please provide: ☐ A summary, ☐ All medical records, or
☐ The following specific information:

_____
_____
_____

I, _____, hereby authorize the release of my medical records to Rocky Medical Clinic.

I understand that this is an uninsured service not covered by my medical insurance plan. *I realize that there may be a charge for this service and that I am responsible for it.* The Alberta Medical Association's Guide to Direct Billing for Uninsured Services (2013) suggests a fee for the transfer of medical records at the request of the patient and that the fee is dependant upon the situation. ***Please contact me concerning the fee prior to copying my records.*** Thank you.

Receiving Doctor:

_____
Patient's Signature

***DENOTES PROFESSIONAL CORPORATION**