** Patients – please send a copy to your previous health care provider//facility and provide a copy of the completed Records Release Authorization to staff.weststeveston@gmail.com*

RECORDS RELEASE AUTHORIZATION

To: (Doctor or Hospital)
Address: Tel: Fax:

I hereby authorize and request you to release to:

[ ] Steveston MedSpa
100-6168 London Road
Richmond, BC V7E 0C1
Tel: 604-448-9595
Fax: 604-304-9595
Email: staff.weststeveston@gmail.com

[ ] West Steveston Medical Clinic
130 – 3755 Chatham Street
Richmond, BC V7E 2Z4
Tel: 604-448-9595
Fax: 604-304-9595
Email: staff.weststeveston@gmail.com

In particular, it would be much appreciated if you would provide a summary of the patient's history and photocopies of consultation reports and diagnostic test results pertinent to the continuity of care. Please do NOT send original records as Steveston MedSpa and/or West Steveston Medical Clinic cannot be held responsible for material lost in transit.

Patient's name: ________________________________

PHN: ________________________________

Address: ________________________________

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I understand that the transfer of records is not an insured service and that there may be a charge for this.

Signature: ____________________________ Date: ___________________

Relationship if signing on patient's behalf: ________________________

In accordance with the College of Physicians and Surgeons Regulations, please do not forward the original chart. Original records must be retained by the transferring physician as required by law.

Thank you.