Authorization for Release of Medical Records

1. Patient (complete in full)

Name – Last, First Middle		Health Card Number
Address		Date of Birth
City	Province	Postal Code
Home Phone	Cell Phone	Email

2. Records Released From:

Trent Hills Family Health Organization
119 Isabella Street
Campbellford, ON K0L 1L0

Telephone: 705-653-1801
Fax: 705-653-5483

3. Records Released To:

Name – Last, First Middle		Telephone
Address		Fax
City	Province	Postal Code

4. I hereby authorize Trent Hills FHO to make all of my medical records and reports available to

Dr: ______________________________ located at ______________________________

5. I understand that this is an uninsured servicer not covered by my medical insurance plan. I realize that there will be charge for this service, **$30 for the first 20 pages and $0.25 for each page after**, as recommended by the OMA. Please contact me concerning the fee prior to copying my records.

Signature of patient:

______________________________ Date: ____________________

If not signed by the patient, please indicate relationship (Parent or guardian of minor patient, or guardian or conservator of an incompetent patient)

Name of Guardian/Representative: ______________________________

Legal Relationship: ______________________________

Date: ____________________ Witness: ____________________