Canadian Diagnostic Network

# MEDICAL RECORDS REQUEST RELEASE FORM

A patient must provide a written request from their physician / primary caregiver to release their medical records.

☐ Personal Use ($55 Administrative Fee) ☐ ON GOING CARE ($0 No Charge)
Please check one of the above boxes.

**CONTACT INFORMATION:**

Name of Patient: _____ _____
*(Last Name)* *(First Name)*

Birthdate: _____ Health Card #: _____ Version Code: _____
*(dd/mm/yyyy)* *(If Applicable)*

Day Phone #: _____ Alternative Phone #: _____

☐ Pick Up (Picture ID required)

**RECORDS REQUESTED:**

**Please specify date range of records requested:** _____ _____
*(from)* *(to)*

☐ Medical Imaging CD
☐ X-Ray(s)
☐ Ultrasound(s)
☐ Mammogram
☐ BMD
☐ Other: Please specify: _____

_____

_____

**PHYSICIAN AUTHORIZATION:**

I request that the above information be provided to the above mentioned patient:

Name of physician: _____

Address: _____

_____ _____
**Physician Signature** Printed Name

_____ _____
Phone and Fax Number Date