Canadian Medical Alliance
Committed to your care

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