Request for Medical Records

Name of Doctor / Medical Facility: _____

Phone Number: _____ Fax Number: _____

Patient's name: _____

DOB: _____

PHN: _____

I, _____ authorize the release of my medical records to Sorrento & Area Community Health Center. Please mail any charts that are larger than 15 pages. Please do not send CD.

Sorrento Health Center
P.O. Box 193
1-1250 Trans-Canada Highway
Sorrento BC, V0E 2W0

Phone 250-675-2167
Fax 250-675-3378

Signature: _____

Date : _____