

**DO NO HARM CLINIC Ltd.**  
#9 – 3151 LAKESHORE DR. SUITE #421  
KELOWNA, BC. V1W 3S9  
FAX: (888) 370-2033 Email: [donoharmclinic@gmail.com](mailto:donoharmclinic@gmail.com)

**CONSENT TO SHARE MEDICAL RECORDS FROM:**

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**Healthcare Practitioner**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

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I \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(print name) DOB (day / month / year) (health card number)

consent to the sharing of a portion of my medical record with the Do No Harm Clinic Ltd. and related referral clinics.

The clinic requests a copy of the patient profile, problem list or other medical document confirming the patient's medical diagnosis.

The complete chart is **not** required. Please keep to a **maximum** of 5 pages.

Any fees associated are the responsibility of the patient.

**Fax back to 1-888-370-2033**

Thank you in advance.

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(Signature of Patient )

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(Date Signed)

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(Date Faxed)

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