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

CONSENT TO SHARE MEDICAL RECORDS FROM:

Healthcare Practitioner
Name: _____
Address: _____
_____
Phone Number:_____
Fax Number:_____

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.

_____ _____ _____
(Signature of Patient) (Date Signed) (Date Faxed)

 revised Feb 2015