Suite 503, 326 11th Ave SW
Calgary, AB T2R 0C5
Phone: 1-844-932-3627
Secure Fax: 1-403-475-1129

CHI Office Use only:
Patient ID #

Date:

RELEASE OF MEDICAL RECORDS

Webclinic is representing the patient indicated below and has been designated to assemble, review, process applications information and schedule appointments related to the inquiries for the patient indicated on this form. The request for release of medical records pertains only to the records related to the specific medical condition in which the patient requires the release.

This is not a request to change physicians. This request is to release patient records for the medical conditions, as stated on the fax cover sheet, only.

Date:

Name of releasing Physician:

Releasing Physician Phone:	Releasing Physician Fax:

Patient Name (as it appears on label):

DOB (yyyy/mm/dd):

/ 12 / 31

Releasing to Dr. Damji and Dr. Ko at Webclinic.

I, _____, hereby authorize you to release my / my family's medical file(s) and any pertinent information regarding my / our health while under your care. I understand this service is not covered by Alberta Health and Wellness, and I agree to pay a reasonable fee for transferring my / my family's medical file(s).

_____

Applicant signature