RELEASE OF RECORDS

To: _____
(Physician's Name)

_____
(Physician's Address)

Regarding:

Patients Name: _____

PHN: _____ **DOB:** _____

I, _____ am requesting the release
(Patient's Name)

of my medical records to Dr. Mathew C. Mosher.

Instructions regarding content whether all or a portion of the file is to be released:

- ❑ **Please release ALL of my medical records.**
- ❑ **Please release the following information contained within my medical records:**

_____

_____

_____

_____ Date: _____
Patient's Signature

_____ Date: _____
Patient's Name - Please Print

_____ Date: _____
Witness Signature

_____ Date: _____
Witness Name - Please Print

For Office Use Only:

Please forward this information:

☐ **Via Meditran (where applicable)**

☐ **Via Mail: Dr. Mathew C. Mosher Inc.**
301-8837 201st Street, Langley, BC V2Y 0C8

☐ **Via Fax: Relevant information to: (604) 888-9301**