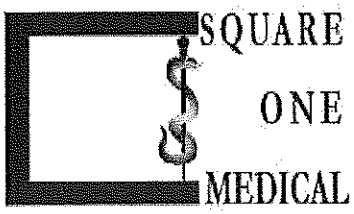

Family Practice & Walk-In Clinic

Patient Consent Form for Medical Record Pickup

Purpose of Consent:
This form grants permission for the below named individual to collect the medical records

Patient Information:
Name:
Date of Birth:
Phone Number:

Recipient Information:
Name of Person Collecting Records:
Relationship to Patient:

Consent to Transfer:
By signing below, I, the undersigned, authorize the release of my medical records as specified above to the individual named in this form.

I also acknowledge that the recipient of the records will be required to sign for them upon pickup.

Patient Signature:
Date:

_____

Authorized Person's Signature (if applicable):
Authorized Person Signature:

_____
Date:

_____
Office Use Only:
Processed by:

_____
Date:

_____
Records Released: ☐ Yes ☐ No
Comments:

_____

4175 Confederation Parkway * Units 1 & 2 * Mississauga * ON. * L5B 0H1
P: (905)848-4880 * F: (905) 848-4882