REBALANCE
SPORTS MEDICINE
rebalancetoronto.com

REQUEST FOR PATIENT'S HEALTH RECORDS FROM A THIRD PARTY

PATIENT INFORMATION			
Last Name:	First Name and Initial(s):	Gender: ❑ M ❑ F	Date of Birth (mm/dd/yyyy):
Street Address:			Postal Code:
City:	Province:	Email:	
Health Card #:		Version Code:	Expiry Date (mm/dd/yyyy):

NAME OF FACILITY WHERE RECORDS ARE BEING REQUESTED FROM
Facility Name:
Physician Name:
Specific Documents Requested:

CONSENT

I, the patient (or legal guardian) named above, hereby authorize the facility indicated above to release the requested medical records to Rebalance Sports Medicine.

Please fax the records at your earliest convenience. The document(s) should be made attention to the following practitioner:

_____
Practitioner Name

_____ _____
Patient or Guardian Signature Date Signed (mm/dd/yyyy)

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