FOOTHILLS FAMILY MEDICAL CENTRE

J.M. BISHOP, MD*, CCFP
J.V. BRANCH, MD*, CCFP
B.J. DORAN, MD*, CCFP
T. J. DOWDALL, MB*, CHBCC
N. W. GRISDALE, MD*, CCFP
T.C. HEMBROFF, MD*, CCFP
E. JABLONSKI, MD*, CCFP
Y. KORCHEMAGIN, MD,CCFP
J. LEMIRE, MD,CCFP
C. POCOCK, MD*, CCFP
G. J. RAY, MD*, CCFP
M.J. SCHUCK, MD*, CCFP
B. L. SIRAY, MD*, CCFP
A. VAN AERDE, MD*, CCFP

*PROFESSIONAL CORPORATION

PO Box 1420
114 – 1St. SW
Diamond Valley, AB T0L 0H0
Phone: (403) 933-4368
Fax: (403) 933-2026
Email: clinic@ffmc.ca

Authorization for Release of Medical Records

_____ has come under my care and I would be grateful if you could
(Patient name)
forward me copies of such relevant records and reports that would be beneficial in the ongoing care

of this patient. **FFMC Physician** _____

I _____ hereby authorize _____
(Patient name) **(Previous Doctor/Clinic)**
Address:_____
Phone #:_____
Fax #: _____

to release a photocopy or fax of my medical records to **The Foothills Family Medical Centre**.

This Authorization for Release of Medical Records is limited to the following:

- ☐ EMR summary
- ☐ Consultant Letters
- ☐ Diagnostic Imaging
- ☐ Operative Reports
- ☐ Any Stress Tests, ECG's
- ☐ Most recent – pap, mammogram, PSA, bone density, FIT, colonoscopy
- ☐ Other _____

PATIENT LABEL HERE

Please do not send the entire chart

I hereby authorize any physician, practitioners, hospital or clinic by whom or where I have been observed or treated for any reason, to give full particulars thereof, including medical history.
I am aware that I will be responsible for any costs associated with this reproduction.

_____ _____ _____
Patient Signature Witness Signature Date