Authorization to Transfer Medical Record & Summary

Patient Information:

Name: _____

Partner (if applicable): _____

Date of Birth: _____

Partner Date of Birth: _____

Address: _____

Phone: _____

Email: _____

Authorization for Transfer of Medical Record & Summary

I intend to remain under the care of my current Family Physician Dr. _____ and I hereby give consent for my Physician to request and receive my chart summary in paper and electronic format.

_____ _____
Signature Date

_____ _____
Spouse/Partner (if applicable) Date

_____
Witness

I also authorize the transfer of the following minors in my household:

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Please return by **Fax: (204) 615-8089,** by **email: kingsbury.medical@gmail.com** or **mail: 7-1099 Kingsbury Ave. Winnipeg, MB. R2P 2P9** by **March 1, 2019**. Thank you.