PCRM Pacific Centre for Reproductive Medicine
The Prelude Network®

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MEDICAL RECORDS RELEASE FORM

Date: _____

PATIENT INFORMATION:

Name:

Date of Birth:

Personal Health Number:

Address:

Telephone number:

I hereby request that my medical records be released to:

Physician/Clinic name: _____

Address: _____

Telephone number: _____

Fax number: _____

OR to:

☐ SELF, for my own personal use

☐ I am aware that there is an administrative fee for the compiling/copying/printing of my records and that payment will be required in advance of records being released.

_____ _____

Patient Signature **Date**