APEX MEDICAL CLINIC
Walk-In & Family Practice
5486, Falsbridge Drive N.E. Calgary, AB, T3J 5H4
Ph: (403) 590 4444 Fax: (403) 798 4567
Mon - Fri 8am - 9pm, Sat - Sun 9am - 7.30pm

Consent Form for Transfer of Medical Record

PATIENT INFORMATION

Name: _____
(surname) *(given name/names)*

Date of Birth: _____
(day/month/year)

Address: ____.

I authorize my health information (Medical Record) to be transferred / disclosed by :-

Dr.of _____.

in accordance with section 34 of the Health Information Act to **Apex Medical Clinic Inc**.

for the purpose of providing me health care.

_____.

I acknowledge that I have been made aware of why I have been asked to consent to the disclosureof the above information, and am aware of the risks and benefits associated with consenting, or refusing to consent, to the disclosure of my health information.

Dated this ____of ,_____.
(day) (month) (year)

_____
Signature of patient / authorized representative*

* if you are signing on behalf of the client, the following information must be provided:

_____ _____
Print Name of Authorized Representative **Print** Source of Representative's Authority
[refer to *HIA* section 104(1)]

_____ _____
Witness Signature Print Witness Name