

*Cabrera Consultants*

**Innisfree Farm**

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**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

I \_\_\_\_\_

apt #, Street \_\_\_\_\_

city \_\_\_\_\_ Province \_\_\_\_\_

zip code \_\_\_\_\_ Telephone # \_\_\_\_\_

PHN / Care Card # \_\_\_\_\_ Date of birth \_\_\_\_\_

HEREBY AUTHORIZE

the medical offices of Dr. \_\_\_\_\_

apt #, Street \_\_\_\_\_

city \_\_\_\_\_ Province \_\_\_\_\_

zip code \_\_\_\_\_ Telephone # \_\_\_\_\_

TO RELEASE THE FOLLOWING MEDICAL RECORDS AND REPORTS FROM MY FILE

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

compiled during the period \_\_\_\_\_ to \_\_\_\_\_

To me, myself, for my personal use.

\_\_\_\_\_

**I understand that once this record is released from the office of the above named health care provider then this provider is no longer responsible or accountable for any events caused by its release.**

Signed \_\_\_\_\_

date \_\_\_\_\_