**Request for Release of Medical Records**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RECORDS TO BE RELEASED FROM:**

Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RECORDS RELEASE TO:**

Qamar Shasadah PT

B-5 2727 Courtice Road

Courtice Ontario L1E3A2

P:905-429-2222

F:905-429-2228

The above patient has recently joined our practice and we are requesting a release of his/her medical records. This will help us to make a better treatment plan for this patient. **Please fax to 905-429-2228.**

**Ultrasound\_\_\_\_\_\_\_\_\_ X-rays\_\_\_\_\_\_\_\_\_\_\_ MRI\_\_\_\_\_\_\_\_\_\_\_ CT Scan\_\_\_\_\_\_\_\_\_ EMG\_\_\_\_\_\_\_ OR\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please see the consent from the patient below:**

I authorize release of my medical records in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. I understand that any costs for this service shall be my responsibility.

Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_