clinic805
COSMETIC SURGERY & SKINCARE CENTRE

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

TO: _____ DATE: _____

FAX: _____

PATIENT NAME: _____

DOB: _____

PHN: _____

PHONE #: _____

I, _____ give authorization for release of my medical records to

_____. Please fax records to: 250-595-8835.

SPECIFICS:

I agree to pay appropriate costs for photocopying, if applicable.

I am nineteen years of age or older.

Dated this _____ day of _____ in the year of _____.

Patient's signature:_____

Please print name:_____

Signature of parent/guardian if patient under 19 years of age:
_____

Please print name:_____