AUTHORIZATION TO RELEASE MEDICAL RECORDS

This form is to request a clients medical records. This form is to be completed by clients, power of attorney, legal representatives or third party requestors (including insurance companies and lawyers not representing the client). Please allow up to 6 weeks for processing.

1 CLIENT INFORMATION

CLIENT LEGAL LAST NAME | CLIENT LEGAL FIRST NAME | CLIENT LEGAL SECOND NAME

PERSONAL HEALTH NUMBER (PHN) | BIRTHDATE (MM / DD / YYYY) | OTHER PROVINCIAL HEALTH NUMBER (IF APPLICABLE)

2 POWER OF ATTORNEY OR LEGAL GUARDIAN (IF APPLICABLE) SUPPORTING LEGAL DOCUMENTATION REQUIRED INDICATING RELATIONSHIP

POWER OF ATTORNEY OR LEGAL GUARDIAN LEGAL LAST NAME | P.O.A. OR LEGAL GUARDIAN LEGAL FIRST NAME | P.O.A. OR LEGAL GUARDIAN LEGAL 2ND NAME

3 RECORDS REQUESTED

TYPE OF RECORD(S) REQUIRED (INDICATE WHICH OF THE RECORDS BELOW ARE REQUIRED)

☐ MEDICAL HISTORY ONLY (MSP) ☐ MEDICAL HISTORY WITH DIAGNOSTIC CODE (MSP) ☐ DRUG HISTORY (PHARMACARE)

REASON FOR REQUEST

☐ MOTOR VEHICLE ACCIDENT (MVA) ☐ **SLIP AND FALL*** ☐ OTHER (PLEASE SPECIFY):

REQUESTED DATES OF RECORDS

START DATE (MM / DD / YYYY) | END DATE (MM / DD / YYYY)

ACCIDENT INFORMATION, IF APPLICABLE

DATE OF ACCIDENT (MM / DD / YYYY) | FILE / REFERENCE # (IF APPLICABLE)

4 NAME OF PERSON/COMPANY AND ADDRESS WHERE RECORDS ARE BEING SENT

PERSON OR COMPANY RECEIVING RECORDS

APT / UNIT | STREET NUMBER | STREET NAME

CITY | PROV | POSTAL CODE

5 PAYMENT (FOR MEDICAL HISTORY (MSP) RECORDS ONLY)

There is no charge to release your own medical records to you (the client) or your lawyer. However, a fee of $50 (CDN) is charged per year of record requested for all other third-party requests, including insurance companies and lawyers not representing the client. If third party request (other than your lawyer), please provide address below for invoicing.

NAME OF THIRD PARTY

APT / UNIT | STREET NUMBER | STREET NAME

CITY | PROV | POSTAL CODE

6 CLIENT AUTHORIZATION *TO BE SIGNED BY THE CLIENT, POWER OF ATTORNEY, OR LEGAL GUARDIAN*

I, the client or power of attorney or the legal guardian named above, hereby authorize Health Insurance BC to release all medical records indicated above to the requestor named in section 4 at the address named in section 4.

☐ By checking this box, I hereby revoke all previously signed authorizations for the release of Medical and/or Drug History Records.

SIGNATURE OF CLIENT / POWER OF ATTORNEY / LEGAL GUARDIAN | SIGNATURE OF WITNESS | PRINT NAME OF WITNESS

DATE SIGNED (MM / DD / YYYY)