BONNYVILLE MEDICAL CLINIC

101, 4610 – 50 Street, Bonnyville, AB T9N 0G2 Phone: 780-826-3346 Fax: 780-826-6362
Website: bonnyvillemedicalclinic.ca

Release of Medical Information

Date: _____

Patient name: _____

Address: _____

Phone number: _____

Date of Birth: _____

Provincial Healthcare Number: _____

I have recently come under the care of Dr. _____ at Bonnyville Medical Clinic. I would be most grateful if you could forward the last two years of the chart and any significant investigations, consults, or procedures to:

Bonnyville Medical Clinic
101, 4610 50 Street
Bonnyville, AB T9N 0G2
Fax: 780-826-6362

I accept that any fees associated with this are my responsibility.
I hereby authorize the release of any medical information pertaining to myself.

Signed: _____
Signature of Patient or Guardian