

Generations Care Clinic

102-3211 152 St. Surrey, BC, V3Z 1H8 | Phone: 604-260-6019 | Fax: 844-444-0673

Authorization for Release / Transfer of Medical Records

Physician / Clinic Requesting From: _____

Phone No: _____

Fax No: _____

Receiving Physician:

Dr. _____

Type of Request (Please select one):

☐ Medical **Summary (for continuity of care)**

Includes: chart summary, recent labs, imaging, and relevant reports (**Not a full chart transfer**)

☐ From _____ to _____

☐ Full **Transfer of Medical Records**

Includes: complete medical chart (all notes, reports, and history)

Please forward the selected records to the physician listed above.

Fees & Acknowledgment

I understand that:

- This service is **not covered by my provincial health plan**
- I may be responsible for any applicable fees
- Fees may vary depending on the type of request (summary vs full transfer)

Patient Chart Label:

Consent

I authorize the release/transfer of my medical records as selected above.

Signature: _____

Date: _____