



REQUEST TO GET MEDICAL RECORD

*Note- Each adult that wants to get their record should fill one of these forms. (ie a couple needs to fill two forms, one for each partner)

Date: _____

Name of Patient: _____

Date of Birth of Patient: _____

Dear Umedical, please provide a complete record of medical records for:

Myself (provide name): _____

To Dr. _____ Fax: _____

AND/OR

My Next of Kin Under 18 years for whom I am guardian (provide name/s)

 I agree to pick up my record IN PERSON and provide personal identification prior to release of my record(s).

(If the records are being released to the patient) I will pick up the record that will be in the form of a USB key, at Umedical between office hours of Monday-Friday 9-12 pm and 1 to 5 pm.

Please fax the records to my doctor directly at the fax number mentioned above.

I agree to pay an administrative fee for each record requested - First 20 pages \$30 (Each page after 20: \$0.25). This payment will be made prior to the creation of the copy of my record and I agree to be invoiced by electronic means.

Signature of Patient Requesting Record(s)

Note: For information regarding guidelines followed for managing your health records please go to the privacy commissioner of Ontario website at www.ipc.on.ca .