Appletree
Medical Group

Medical Information
Patient Release Form

Patient Information

Patient Name, incl. Maiden Name if applicable (First name, Last name) [PRINT]

Date of Birth (mm/dd/yy)

Street Address

City & Province

Postal Code

Main Contact Phone Number

Health Card # including version code
(if covered by OHIP)

Hereby authorize:

Name of Physician or Healthcare Facility

Medical Information Requested

To release medical records to:

Healthcare Provider Information

Name of Physician

Appletree Medical Group

Name of Healthcare Facility

Main Contact Phone Number

Fax #

Patient Consent

I authorize the release of my medical records in accordance with the specifications listed above.

Signature

Date

If signed by a person other than the patient noted above, state the relationship, and complete the personal information section below:

◯ Parent ◯ Legal Guardian ◯ Other: _____

Name (First, Last)

Street Address

City, Province & Postal Code

Telephone #