Maple Grove Medical Clinic

Medical Records Transfer Request Form

I, _____, hereby authorize and request a copy of all my records in your possession concerning any diagnosis, prognosis, and recommendation, as well as any other data pertinent to my care to be transferred to or from (delete as appropriate) Maple Grove Medical Clinic.

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P ATIENT INFORMATION

Patient Full Name (Please Print):	
Patient Address:	Phone Number:
Date of Birth (DD / MM / YYYY):	Health Card #:

TRANSFERRING PARTY

Physician:	Clinic Name:
Phone Number:	Fax Number:

RECIPIENT

_____ _____

Patient / Guardian Signature **Date**