island health

MEDICAL GENETICS
Victoria General Hospital
1 Hospital Way, Victoria, BC V8Z 6R5

Tel: (250) 727-4461
Fax: (250) 727-4295

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Name of Person: (i.e. the name of the patient whose health information is being requested)

_____

Last Name **First Name** **Middle Name / Initial**

Birth Date: _____ ✓ **Former Name**: _____
(month/day/year) (if applicable)

Address: _____
(Including Street, Mailing & Postal Code)

Treatment Period Requested: _____ **Our Reference VI #**
(approximate date) (or X-REF name)

Personal Health Care #: _____ **Issuing province:** _____

HEALTH CARE FACILITY RELEASING INFORMATION:

- ❑ Hospital: _____
- ❑ Doctor's Clinic: _____
- ❑ Other: _____

INFORMATION OR SPECIMEN REQUESTED:

✓Physician Letters / Consultations
✓Medical Imaging Reports
✓Pathology / Autopsy Reports
❑ Therapy Assessments (may include Developmental/Physiotherapy/Occupational Therapy/Nutrition/Social Work)

✓Genetic Testing / Cytogenetic Results
❑ Biochemical Testing Results
❑ Paraffin tissue blocks
❑ Other (please specify) _____
_____

Related to: _____
_____

I request that the above information be provided to the designated recipient at the following address:

Medical Genetics Clinic, Victoria General Hospital, 1 Hospital Way, Victoria, BC V8Z 6R5 Canada
Phone: (250) 727-4461, FAX: (250) 727-4295

SIGNATURE of patient or patient's legal representative _____
Print name_____ **DATE**: _____
Relationship to patient whose records are being requested _____

NOTE: Please send signed original by mail. For certain institutions a photocopy or faxed copy may be as valid as the original. This authorization will expire six months from the above date. Requests for further information/records will require a new form. (Statutory Provisions relevant to this request: Freedom of Information and Protection of Privacy Act s.4 and s.5)