CADENCE
HEALTH CENTRE

# AUTHORIZATION TO RELEASE MEDICAL RECORDS

**TO DOCTOR:** _____ **DATE:** _____

Address: _____

Telephone: _____

Fax Number: _____

**Please note that if the files are more than 15 pages, please DO NOT fax, mail or e-mail preferred.**

This is to inform you that I have chosen to attend Dr. _____ at Cadence Health Centre, as my personal physician.

Please forward the following to my new physician, in order to provide me continuing care:

- o All my medical records, including my chart, consult notes and reports, diagnostic and blood reports
- o The following listed: _____
  _____

I understand that this service is not recognized as "medically required service" and is not covered by my provincial medical plan (OHIP). I realize that there may be a charge for this service and I am responsible for it. I authorize you to bill me at my current address.

**PATIENT NAME:**

**PLACE CLINIC LABEL HERE**

Patient Signature over Printed Name: _____

***Please release all documents to:***

**Cadence Health Centre**
200 Spadina Ave., Toronto, ON M5T 2C2
Tel: 416-203-8600 Fax: 416-203-8602
E-mail: hello@cadencehealthcentre.com