MEDICAL RELEASE FORM

PATIENT INFO

Name:_____Birthdate:_____
Last, First

Phone:_____ AHC#:_____

I, _____, wish for the following:
Patient name (printed)

☐ **I AUTHORIZE** my medical chart to be transferred to Dr. Adhikar Gokul, and sent to:

Edmonton Comprehensive Care & Family Medicine
110, 6925 Gateway Blvd W, Edmonton, AB T6H 2J1
Fax: 780-306-5757, Phone 780-306-5656

Please be advised that I am requesting release of all of my medical records From Dr. Adhikar Gokul to be transferred to his new clinic (as per above), including anything regarding myself and/or family members, as per my authorizing signature below.

Please send information from the past **18 MONTHS** or any other information you feel may be relevant. **An original file will not be returned.**

OR

☐**I DO NOT** want my chart transferred at this time.

Patient/Guardian Signature:

_____DATE_____

Guardian Name (if applicable): _____

Please email or fax completed forms, Attention: Clinic Manager to:
info@eccfm.ca or 780-306-5757, Attention: Clinic Manager