

# MEDICAL RELEASE FORM

## PATIENT INFO

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
*Last, First*

Phone: \_\_\_\_\_ AHC#: \_\_\_\_\_

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

**I AUTHORIZE** my medical chart to be transferred to Dr. Brock Organ, 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. Brock Organ 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](mailto:info@eccfm.ca) or 780-306-5757, Attention: Clinic Manager