EDMONTON
COMPREHENSIVE CARE & FAMILY MEDICINE

Chart/Medical Records Transfer Request from other clinic to ECCFM or CCC

Date : _____

Previous Clinic : _____

Clinic Phone Number : _____ **Clinic Fax:** _____

Dear Dr. _____

Patient's information:
Patient Name:_____
Personal Health Number:_____
Date of birth:_____
Patient phone number:_____

The above named patient is now under my care. I would appreciate you sending, at your earliest convenience, any medical information that may be in your possession.

Please provide :
- **( ) Current medical records**
- **( ) Synopsis of current diagnosis and treatments**
- **( ) Any pertinent diagnostic reports**
- **( ) Complete medical file**
- **( ) Other (please specify)** _____
  _____

This is an uninsured service not covered by the Alberta Health Care Insurance Plan. The Alberta Health information Act prescribes a fee for the transfer of medical records at the request of the patient. Any fees associated with this request are the patient's responsibility. Thank you.

_____ _____
Patient Consenting Signature **Date**

_____ _____
Physician Name **Physician Stamp/signature**

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