



RELEASE

Direction for Release of Medical Records

I, the undersigned, do hereby authorize One Fertility to release:

- any and all of my medical records (including all prior medical history) and/or medical information
- a specific report, form, note described as : _____

to:

- Myself
- Physician
- Midwife
- Healthcare Professional
- Other Individual

Patient Name: _____

(please print clearly)

Recipient Address: _____

Recipient Phone and/or Fax: _____

Please send the information via:

- Pick Up at ONE Fertility (*with photo ID*)
- Fax (*ensure fax number is provided above – most common for other healthcare providers*)
- Regular Mail (Canada Post)
- Courier (*Costs may be incurred for tracking capability*)
- Secure Message (**ONLY applicable for small files (<10MB) to patient directly (Option #2). Full chart option is not available**)

Patient Name: _____ DOB: _____

(please print clearly)

Health Card: _____ Version Code: _____

Patient Signature: _____ Date: _____

****You may only request your own personal health information and/or records.****