



Ontario Network
of Experts in Fertility
life through knowledge



Department
of Obstetrics
and Gynecology

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RELEASE

Direction for Release of Medical Records

I, _____, do hereby authorize One Fertility to release:

Patient Name

- ☐ 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

Recipient 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.****