

Consent to Transfer of Medical Records

From Former Clinic to Elicare Medical Clinic

Please check off the location for records are to be transferred to:

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Elicare Lougheed Family Practice | Burnaby (Fax: 778-712-9966) |
| <input type="checkbox"/> Elicare Lansdowne Medical Clinic | Richmond (Fax: 604-242-1867) |
| <input type="checkbox"/> Elicare Royal City Medical Clinic | New Westminster (Fax: 604-545-0428) |
| <input type="checkbox"/> Elicare Poco Medical Clinic | Port Coquitlam (Fax: 604-554-0466) |

To:

Former Doctor/Clinic: _____

Fax number: _____

Phone number: _____

Re:

Patient's Name:	
Date of Birth:	
PHN:	
New Doctor:	

PATIENT ACKNOWLEDGEMENT

In the future, I/we will be attending the above medical office. In order to maintain continuity of care for myself (and my family members) please forward, at your earliest convenience, a copy of my entire chart to the above address or fax number. Please use only one-sided photocopies, or if possible send records as a PDF file on a disk. **THE ORIGINAL RECORD SHOULD NOT BE SENT**, in keeping with the policy of the College of Physicians and Surgeons of BC.

I understand that you may charge a fee for this service and that this fee is not covered by my medical plan. Please bill me for any service fee. Thank you.

Patient or Guardian Signature: _____

_____ Dated: _____