REBALANCE
SPORTS MEDICINE

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REQUEST FOR PATIENT'S HEALTH RECORDS FROM A THIRD PARTY

PATIENT INFORMATION

Last Name:	First Name and Initial(s):	Gender: ❑ M ❑ F	Date of Birth (mm/dd/yyyy):
Street Address:		Postal Code:	
City:	Province:	Email:	
Health Card #:		Version Code:	Expiry Date (mm/dd/yyyy):

NAME OF FACILITY WHERE RECORDS ARE BEING REQUESTED FROM

Facility Name:

Physician Name:

Specific Documents Requested:

CONSENT

I, the patient (or legal guardian) named above, hereby authorize the facility indicated above to release the requested medical records to Rebalance Sports Medicine.

Please fax the records at your earliest convenience to 1-866-338-1236. The document(s) should be made attention to the following practitioner:

____
Practitioner Name

____
Patient or Guardian Signature

____
Date Signed (mm/dd/yyyy)