CITRUS MEDICAL CENTRE

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Consent to Release Health Records Form

Date:
To: [Name of MD/Facility] :
Phone:
Fax:

Please select one of the two options:

- ☐ **I consent to Citrus Medical releasing my medical records to the doctor indicated above**
- ☐ **I consent to having my records sent to the doctor indicated below:**

☐ **Dr. Alia Gray**	☐ **Dr. Cameron Caners**	☐ **Dr. Amine Smair**
☐ **Dr. David Field**	☐ **Dr. Irene Fung**	☐ **Dr. Nikki Shah**
☐ **Dr. Shaireen Kassam**	☐ **Dr. Nazanin Rajabi**	
☐ **Dr. Merry Maclellan**	☐ **Dr. Bethany So**	
☐ **Dr. Emily McDonough**	☐ **Dr. Lauren Briggs**	
☐ **Dr. Monica Pham**	☐ **Dr. Ravinder Lall**	
☐ **Dr. Hinal Sheth**	☐ **Dr. Farahnaz Daya**	
☐ **Dr. Tabitha Tonsaker**	☐ **Dr. Sylvia Lee**	

Please send the following: (*WE DO NOT ACCEPT CDs*) & we use PS Suite if you want to export the chart.

- ☐ **Medical summary of the last few years entire records :**
- ☐ **Consent notes -**
- ☐ **Other (please specify) :**

Name of patient:
Date of Birth:
Health Card Number:
Patient Signature:

Date: