Équipe de santé familiale
Clarence-Rockland
Family Health Team

Chart Transfer Request

Transfer the following information:

☐ Complete copy of all records:
- All relevant consultations, imaging, and medical tests or procedures (e.g. pap tests, colonoscopies);
- Laboratory results;
- Vaccination history; and
- Any pertinent information that will have bearing on the patient's health going forward.

☐ Other medical information: _____

Where to transfer:

☐ from other party to CRFHT ☐ from CRFHT to other party

CRFHT

Clarence-Rockland Family Health Team
2741 Chamberland Street
Rockland, Ontario
K4K 0B4

Other party:

Physician name: _____ Clinic: _____

Address: _____

City: _____ Province: _____ Postal code: _____

Telephone: _____ Fax: _____

Patient acknowledgement and agreement

I authorize the release of my medical records as noted above. I understand that I am responsible for any costs for this service, and that CRFHT will return the records to me when they have been scanned into my chart.

Name: _____ (please print)

Signature: _____ Date: _____

Photo ID (type and #) _____ Date of birth: _____

Clinic witness: _____

Patient label: