

Access by Authorized Representative

I am a legally authorized representative of the patient named above and have attached proof of that representation. I hereby request access to the patient's personal records on his or her behalf.

Authorized representative's contact information

Mr / Mrs / Ms (please circle)

Street address:

Last name: _____ City /town: _____

Prov. _____

First name: _____ Postal code: _____

Fax: _____

Health card number: _____ Tel: (home) _____ (bus)

Date of birth (dd/mm/yy): _____ Email address:

X

Authorized Representative Signature

Date (dd/mm/yy)