# Generations Med Clinic

105-6680 152A St.
Surrey, BC, V3S 7J1
Phone: 604-260-4488
Fax: 778-372-9600

## Authorization for Release / Transfer of Medical Records

**Physician / Clinic Requesting From: _____**
**Phone No: _____**
**Fax No: _____**

**Receiving Physician:**

**Dr. _____**

## Type of Request (Please select one):

☐ **Medical Summary (for continuity of care)**
Includes: chart summary, recent labs, imaging, and relevant reports
**(Not a full chart transfer)**

☐ From _____ to _____

☐ **Full Transfer of Medical Records**
Includes: complete medical chart (all notes, reports, and history)

Please forward the selected records to the physician listed above.

## Fees & Acknowledgment

I understand that:

- This service is **not covered by my provincial health plan**
- I may be responsible for any applicable fees
- Fees may vary depending on the type of request (summary vs full transfer)

## Patient Chart Label:

## Consent

I authorize the release/transfer of my medical records as selected above.

**Signature: _____**
**Date: _____**