



## AUTHORIZATION FOR MEDICAL RECORD TRANSFER

PLEASE SIGN THIS FORM AND RETURN IT TO RSRS BY FAX OR MAIL (ALONG WITH PAYMENT IF STILL REQUIRED)

**Gary Larivee**  
**21 Aldborough Ave.**  
**St. Thomas, Ontario, Canada**  
**N5R 4S8**

NOTE: WE WILL NOT RELEASE MEDICAL RECORDS WITHOUT RECEIPT OF THIS SIGNED FORM.

\*\*For each record released, we must have a signature from the patient / authorized requestor / legal guardian \*\*

519 633 8952

glarivee@sympatico.ca

| Patient(s): Last Name | First Name | Date of Birth | <i>*PATIENT (16 years or older) OR Authorized Signature Below*</i> |
|-----------------------|------------|---------------|--|
| Larivee               | Gary       | 24-Jan-40     |  |

Patient(s) of: Dr.A.M. Morrow

Scarborough

The following fee is set by provincial Medical Association guidelines for the location, clerical work, reproduction and release of the patient(s) medical record(s):

Total Fee: \$123.21    Deposit of: \$123.21    = Balance    \$0.00

### Method of Delivery

Secure Download

### Additional Notes

\*\*\* Note: Remember to make a copy of the record for yourself - Keith

By signing this form, each patient / authorized representative, confirms his/her right and authority to receive the information requested. I confirm that RSRS, in releasing the information, is exercising good faith and reasonable action given its powers and duties under PHIPA 2004, c.3, Sched. A, s.71 (1).

Signature (of patient or authorized individual):

Date:

X

Note: This authorization form is valid for 60 days from the date of signature.

#88985

30-Mar-11