



TRANSFER OF MEDICAL RECORDS – PATIENT AUTHORIZATION

Oceanstone Medical Clinic
Unit 1, 15777 Marine Drive, White Rock, V4B 1E5
Phone: 778-375-2263 Fax: 778-375-2264
admin@oceanstonemedical.ca

PATIENT INFORMATION

Full Name: _____ DOB (DD/MM/YYYY): _____

PHN: _____ Phone: _____

Email: _____

Address: _____

NEW PHYSICIAN NAME: _____

PREVIOUS CLINIC / PHYSICIAN INFORMATION

Physician Name: _____

Phone: _____ Fax: _____

Clinic Name & Address: _____

RECORDS REQUESTED

- ☐ Complete medical record
- ☐ Please follow the delivery instructions below.

AUTHORIZATION

I authorize the release and transfer of my medical records to Oceanstone Medical Clinic.

I understand that a transfer fee may apply and that payment is my responsibility.

Patient Signature: _____ Date: _____

IMPORTANT:

Fax transfers are limited to 150 pages per patient, including cover sheets. If the complete record exceeds 150 pages, please send the entire record using an encrypted USB, a secure encrypted electronic transfer or our secure upload link. Please do not split larger records into multiple fax transmissions.

To request a secure upload link from us, please email admin@oceanstonemedical.ca. For other transfer enquiries or to arrange encrypted USB delivery, contact 778-375-2263 or the same email address.

Please do not send medical records as ordinary email attachments. Provide any decryption password separately by telephone. **CDs and mailed paper records are not accepted.**