



## 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

Please fax this completed form to the patient's previous clinic to request transfer of medical records.

### PATIENT INFORMATION

Full Name: \_\_\_\_\_ DOB (DD/MM/YYYY): \_\_\_\_\_

PHN: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

NEW PHYSICIAN NAME: \_\_\_\_\_

### PREVIOUS CLINIC / PHYSICIAN INFORMATION

Clinic / Physician Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Clinic 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, send the entire record by encrypted USB or secure encrypted electronic transfer. **Do not split larger records into multiple fax transmissions.**

For transfer enquiries or to arrange USB delivery or secure electronic transfer, contact 778-375-2263 or admin@oceanstonemedical.ca. 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.