Patient Information

Legal name:	Former last name:
Date of birth:	Health card #:
Address:	Home phone:
	Mobile phone:
	Work phone:

Authorization

I hereby request that a copy of my medical information/documentation pertaining to my previous egg retrieval procedures and subsequent egg donations performed at _____ be provided to Egg Helpers Ltd. by email at sjensen@egghelpers.com.

Printed name	Signature of patient or legal representative
Date	Relationship to patient if legal representative

Note: In the case of a legal representative signing the authorization, proof of authority to act on the patient/client/resident's behalf, (e.g. copy of Personal Representative Agreement) must be attached. If requesting on behalf of a child, consent from the child may be required.

This authorization will expire twelve months from the above date. Requests for further records will require a new form. (Statutory Provisions relevant to this request: Freedom of Information and Protection of Privacy Act s.4 and s.5)

Please note, unless notified, response will be within 30 business days (as per FIPPA s.7)
Release of Pt. Records Form—Oct 2013