BC Cancer Agency
CARE + RESEARCH
*An agency of the Provincial Health Services Authority*

# AUTHORITY TO DIVULGE INFORMATION TO HEREDITARY CANCER PROGRAM

**HCP OFFICE USE**

UNIT

AGENCY CHART No.

SURNAME GIVEN NAME

D.O.B. HEALTH CARE PLAN No.

I hereby authorize _____
(Medical Facility where cancer was diagnosed / Genetic Clinic where genetic counselling occurred)

_____
(address)

to divulge information regarding:

_____ _____
(last name, first name, middle) **(HC - ID# - our ref)**

_____ _____
(date of birth) (date of death, if applicable)

Specific Information requested: _____

☐ Pathology report confirming diagnosis of _____ cancer

☐ Oncology consult _____

☐ Medical records regarding _____

☐ Genetic consultation records (including pedigree, test results) _____

☐ Other _____

_____ _____
(name - printed) (relationship to patient)

_____
(signature)

_____
(witness signature)

_____
(date)

Please send to: _____ at the address below

**PLEASE RETURN A COPY OF THIS FORM WITH THE REQUESTED RECORDS OR QUOTE THE HC - ID REFERENCE # ABOVE**

**HCP office use**

ROI - date received _____

ROI - date sent _____

ROI - records received _____

Hereditary Cancer Program
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