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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