600 West 10th Avenue
Vancouver, BC, Canada, V5Z 4E6
Tel: 604-877-6000 x 2101
Fax: 604-873-5384

# REQUEST TO ACCESS HEALTHCARE INFORMATION

The information on this form is collected under the authority of the Freedom of Information and Protection of Privacy Act and will be used only for the purpose of responding to your request.

| | |
|---|---|
| ***Patient's Last Name:*** | ***Date of Birth:*** |
| ***Patient's First Name:*** | ***PHN #:*** |
| ***Release healthcare information of the patient named above to:*** | |
| ***Physician Name:*** | |
| ***Address:*** | |
| ***City:*** | |
| ***Billing number (MSC #):*** | |
| ***Physician fax number:*** | |
| ***Physician phone number:*** | |
| ***Please Release Healthcare information relating to the following Diagnostic Cytology Results*** | ***Case ID #*** |
| ***By signing below I confirm that I have legal authority to obtain these results and I hereby authorize BC Cancer to release the records requested*** | |
| ***Physician signature:*** | ***Date Signed:*** |