RoseHealth
MEDICAL & OPTOMETRY
60 - 401 Ledingham Way Saskatoon S7V 0C4 SK (306) 664-6336 (306) 664-6337

Consent to release Information

To: _____

Clinic: _____ **Address:** _____

Phone: _____ **Fax:** _____

I, _____, hereby release my information to Dr. _____ at RoseHealth Medical & Optometry

Please include only relevant information.

- ☐ Entire chart
- ☐ Specific items from chart (please specify):

_____

_____

RoseHealth Medical & Optometry has an entirely computerized medical records system. We have no paper charts and have no storage facilities for paper chart storage. Any information transferred to RoseHealth from your previous physicians will be reviewed by your family physician at RoseHealth and returned to your previous physician. RoseHealth will NOT accept any original medical records or any consequences or liability resulting from loss of any original document sent to us.

Your signature below indicates that you have read and understand the above, and authorize a copy of your medical records to be transferred to us.

Patient Name: _____ **PHN:** _____

DOB: _____

Signed: _____

Witness: _____ **Date:** _____