PCRM Pacific Centre for Reproductive Medicine

To: _____

Fax: _____

RE: _____
(First Name) (Middle Name) (Surname)

DOB: _____
(Day) (Month) (Year)

PHN: _____

The above named patient has come under my care and I would be most grateful if you would forward to me, at your earliest convenience, any medical records and/or reports that are in your possession. Thank you for your time.

Sincerely,

Dr. Ken Seethram (26040) Dr. Jeff Roberts (28725) Dr. Jon Havelock (28815)
Dr. Caitlin Dunne (64341) Dr. Tim Rowe (06365)

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please release the following information:

☐ All Medical records	☐ Art Cycle Results	☐ Consultation Letters
☐ History & Physical exam	☐ Hysterosalpingogram	☐ Semen Analysis
☐ Laparoscopy Reports	☐ Blood Group	☐ Day 3 FSH
☐ Rubella Titre	☐ SHG	☐ Other Operative Reports

I hereby authorize _____ to release any medical records of mine in their possession to the above named Doctor(s).

SIGNATURE OF PATIENT: _____

WITNESS: _____

DATE: _____

500 – 4601 Canada Way, Burnaby BC V5G 4X7 **T** 604.422.7276 **F** 604.434.5522