Crossroads FAMILY PRACTICE

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Holly Zwicker MD, CCFP
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Jill Robertson MD, CCFP
Laci Williams MD, CCFP
Robyn Langelaan MD, CCFP

Authorization for Medical Record Release

PATIENT: _____ **D.O.B:** _____ **HC#:** _____

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Parent or Guardian (if under 18 years old) _____

The above named patient(s) will be attending Crossroads Family Practice and is (are) requesting their chart(s) to be transferred.

I hereby authorize any physician, practitioner, hospital or clinic, by whom or where I have been treated for any reason to give full particulars thereof, including prior history, lab work and diagnostic imaging reports. Thank you.

Date: _____

Signed: _____