

# Fort St. John Family Practice Associates

10011 – 96<sup>th</sup> Street  
Fort St. John, BC V1J 3P3  
Tel: (250) 785-6677  
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## REQUEST FOR MEDICAL RECORDS

**FORMER PHYSICIAN:** \_\_\_\_\_ **TEL:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

I hereby authorize the release of my medical records to Dr. \_\_\_\_\_ who has agreed to become my primary care physician. The original records should not be sent in keeping with the policy of the CPSBC (section 6.2C). **Original charts will not be returned.** A detailed summary is sufficient along with most pertinent information. I understand that this service is not recognized by the MSP as a “medically required service”. There may be a charge from my previous doctor to photocopy and send records and I am willing to be responsible for these charges (BCMA fee guide item 00093 is up to \$40 for “record transfer” and possibly up to \$138.00 for “review of records by physician”).

**\*\* In some situations it may be possible to transfer records electronically. This office currently uses the MOIS system. Please contact our office if you would like to transfer records electronically \*\***

**PLEASE NOTE** that some patients may be charged a fee for the review of their medical records once received at our clinic and the fee may vary according to the quantity of material received (BCMA fee guide item 00095 up to \$200.00). Please discuss this with your physician if you have any questions.

<u>PATIENT NAME</u>	<u>DATE OF BIRTH</u>	<u>PHN</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### PATIENT ADDRESS

\_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE OF PATIENT OR GUARDIAN**

\_\_\_\_\_  
**DATE SIGNED**

\_\_\_\_\_  
**WITNESS**

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### GENERAL PRACTICE ASSOCIATES

R. G. Moody (MB,BS)  
W.G. Watt (MD)

P. de Bruyn (MBChB)  
K.B. Page (MBChB,DA)

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