

MEDICAL RELEASE FOR PATIENTS LEAVING EWFHT

Erin Clinic					Rockwood Clinic					
Dr. Blair Cappel		Dr. Laura Daly Dr. Kamakshi Ganesan Dr. Nancie Parent						Dr. Alejan Dr. Andre	dra Marin w Martin	
Date MM/	B 1T0 P-833-9396 P-833-9838 /DD/YY: k one of the		ooxes: for each person nam	ned below, a	Phone: Fax:	519-	N NOB 2KO 856-4611 856-4612	ared an	d forwarded to:	
New Dr:										
City:	Province:			Postal Code:						
Fax:						l l				
appropriate Please note required to	that when personal show photo	ked at the to picking up a o ID at the ti	for each person name op of this form. medical file summar me (i.e., driver's licer	y, anyone ag	ed 16 years or	over	must pick			
All informa	tion below i	S REQUIRED): 						If picking up:	
Firs	st Name		Last Name		te of Birth D/MM/YY)	i	Signatui if 16 year		EWFHT Staff Witness Signature	

Please see Page 2 for payment options

^{**} Please bring form to either clinic for processing and a quote for the cost of this service, as it is not covered by OHIP

Credit Card Number:							
Name on Card:							
Expiry Date:							
Number on back of card:							
Visa or Mastercard							
Cheque payable to The East Wellington Family Health Team (EWFHT)							
Do you require a receipt? Yes No No							

Payment must be received before record transfer can be completed. Please use the following options:

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