POLO

HEALTH + LONGEVITY CENTRE

AUTHORIZATION FOR PATIENT RELEASE OF MEDICAL INFORMATION & RECORDS

CLINIC NAME: _____

PHYSICIAN NAME: _____

PHONE: _____ FAX: _____

By signing below, I _____, request the clinic listed above, to release the following personal medical information to Polo Health + Longevity Centre (PHLC) to the attention of Dr. Safia Kassam, ND.

(please check):

- ☐ All Clinical Records
- ☐ Recent blood test results
- ☐ Recent imaging
- ☐ Other: _____

PATIENT NAME: _____

PHN (Care Card)#: _____

DATE OF BIRTH: _____

PHONE: _____

DATE: _____ **SIGNATURE:** _____

Please fax or mail records to:

Attention: DR. SAFIA KASSAM, ND

Address: 711 Columbia Street,
New Westminster, BC
Fax: 604.544.7657
Email: info@polohealth.com