Sunnyhill Pediatric Clinic

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Courtney Leach, MD, FRCPC * **Professional Corporation**

SUNNYHILL PEDIATRIC CLINIC

HEALTH INFORMATION ACCESS REQUEST

Patient Name: _____

Patient Date of Birth: _____

Patient Health Care Number: _____

I would like to request the following health information for the patient mentioned above from

SUNNYHILL PEDIATRIC CLINIC: _____

_____

(specify full chart, partial chart, etc)

I understand the information will be provided to me on a USB drive and there is a $35.00 fee associated with it.

Dated this _____ of _____ , _____
(day) (month) (year)

_____
Signature of patient/authorized representative *

*If you are signing on behalf of the patient, the following information must be provided:

_____ _____
PRINT Name of Authorized Representative Relationship to Patient