Riley Park Village
200 – 1402 8the avenue N.W.
Calgary, AB T2N 1B9

Phone: 403.452.0999 Ext.. 113
Fax: 403.984.5448
https://caleohealth.ca/medical-records/

AUTHORIZATION TO RELEASE INFORMATION

PROTECTED HEALTH & MEDCAL INFORMATION TO BE RELEASED FROM CALEO HEALTH

Date: ____

Patient/Organization: ____

Address: ____

Telephone# ____________________________ **Fax#** ____________________________

Please specify which Doctor(s) you are requesting records from: ____

This is to certify that the above named patient has requested that Caleo Health release a summary of all relevant medical records that may be in your possession,
or any documents related to the following: ☐ All Documents
☐ Laboratory Investigations ☐ Diagnostic Imaging ☐ Consultation reports

☐ Other Specifically: ____

Patient consent:

I, ____________________________________, hereby authorize the release of copies of my medical records, or specific parts of my medical records, as indicated above.

I understand that this is an uninsured service, not covered by my provincial medical insurance plan. I realize that there may be a charge for this service and that I am responsible for paying any associated fees. However, I wish to be contacted concerning the charges BEFORE my records are copied. Thank you.

Patient Signature: _________________________________Date:_______________________________________

If you are the guardian for the patient, please clearly print your name: ___________________________________

Witnessed by: ___________________________________ Date: _______________________________________

CONFIDENTIAL INFORMATION:

This message is intended only for the use of the addressee, individual or entity, and may contain information that is **privileged, confidential and exempt from disclosure under Applicable law**. If you are not the intended recipient, you are hereby notified that any **dissemination of this communication is strictly prohibited**. If you have received this communication in error, please notify us immediately by phone.