Adam Norris, MD, DABFM, CCFP (AM)

Family Medicine
Dr. Adam Norris Medicine Professional Corporation
203-60 Hatt Street, Dundas, ON, L9H 7T6
P: (905) 627-1800 F: (905) 627-1700
www.norrismd.com

REQUEST FOR MEDICAL RECORDS

DATE: _____

Dear Clinic,

I would appreciate receipt of the following medical information regarding the undersigned patients who hc recently joined my practice.

Patient Name: _____
Date of Birth: _____
Current Address: _____
Home Phone: _____
Cell Phone: _____

Medical information requested (please send only the following):

- ☐ Copy of all records
- ☐ All consultation and discharge summaries
- ☐ A summary of all immunizations
- ☐ Significant Medical History (ie Cumulative Patient Profile)
- ☐ Other: _____

Patient Consent

I, the above named, give permission to Dr. / NP _____ to send all information via Fax to (905) 627-1700 or USB Drive.

Signature of patient(s): _____
Date: _____

Witness: _____