Sina Medical & Aesthetics Clinic
505 Smithe St., Vancouver, BC V6B6H1
P: 604-336-7462 **F:** 604-336-7463

Release of Medical Records Request

Name and Address of Former Physician(s):

CLINIC 1	CLINIC 2	CLINIC 3
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
PHONE: _____	PHONE: _____	PHONE: _____
FAX: _____	FAX: _____	FAX: _____

*** **NOTE: both phone and fax numbers are REQUIRED to contact each clinic.** ***

Name of New Physician:

☐ Dr. Kathy Rahnavardi, *MD* ☐ Dr. Christina Wang, *MD* ☐ Dr. Nooshin Nikoo, *MD* ☐ Dr. Negar Hafizi, *MD*

☐ Dr. Pierre Receveaux, *MD*

Patient Name:	
Current Address:	**PHN:**
	DOB (MM/DD/YYYY)**:**
	Phone:

Dear Doctor,
In the future, I will be attending the above medical office. In order to maintain continuity of care for myself) please forward, at your earliest convenience, a summary of my chart and/or copies of any pertinent reports to Sina Medical Clinic. THE ORIGINAL RECORD SHOULD NOT BE SENT, in keeping with the policy of the College of Physicians and Surgeons of BC. I understand that you may charge a fee for this service and that this fee is not covered by my medical plan. Please bill me for any service fee. Thank you. I understand that for any transfer of medical file there may be a transfer fee and I will be responsible for full payment of this fee to my previous clinic(s).

Patient Name: Date (MM/DD/YYYY): _____

Signature of Patient or Guardian: