RASCI
RECORDS ACCESS SERVICES CANADA, INC.

"access records - electronically"
Call Us: 800-971-8038
info@rasci.ca

FAX FORM TO: 800-928-2503

1. Patient (complete in full)

email address (if any):		
Name - Last, First, Middle	Health Card Number **Last 4 digits only**	
Address:	Telephone:	
City / Province / Postal Code	Date of Birth (mm/dd/yyyy)	

2. Records Released From: (Physician)

Name - Last, First, Middle	
Address:	Telephone:
City / Province	Postal Code

3. Records Released To: (Physician Name or Patient Name)

Name - Last, First, Middle	Telephone:
Address:	Fax:
City / Province	Postal Code
I am in Need of a New Physician **[ ]** YES	

4. I understand that this is an uninsured service and may not be covered by my medical insurance plan. I will be responsible for paying fees for this service according to approved guidelines.

5. Signature of Patient: **X**_____ Date: _____

Witness: **X**_____ Date: _____
A Witness may be a family member

Print Witness Name: _____ **WITNESS SIGNATURE IS REQUIRED**

6. If not signed by the patient, please indicate relationship:
[ ] Parent or guardian of minor patient **[ ]** Guardian or conservator of an incompetent patient

7. Name of Guardian / Representative: _____

Legal Relationship: _____

8. I hereby authorize (*Name of Executor/Estate Trustee, if applicable)*_____

to make all of my medical records and reports available to Dr: _____ located at

_____