PAGDIN HEALTH
LIVING LONGER BETTER

Request for Medical Records

Doctor Name:_____

Clinic Name: _____

Clinic Phone:_____

Clinic Fax:_____

RE:_____
DOB:_____

Please release the medical records related to my treatment under your supervision. This information will be used to further assist with my medical care:

Please include the following:

- Chart Notes
- Lab Results
- Diagnostic Imaging
- Specialist Consultations

Please fax or mail these records to:

Dr. Pagdin
#201-3320 Richter Street
Kelowna BC V1W 4V5
Ph: 250.717.3200
Fx: 250.717.3220

Thank you

Pagdin Health