Request for Medical Records

Date: __________________

I, ________________________________ with a date of birth of ______________________ request
Patient Name DOB

the release of my most recent Hematology Profile (CBC test) from Dr. ___________________
Family Physician Name

at __________________________.
Clinic Phone Number

<u>Please fax or mail these records to:</u>
Dr. Grant Pagdin
#1-1131 Lawson Ave
Kelowna, BC V1Y 6K3
Ph: (250) 717-3200
Fx: (250) 717-3220

Thank you,

_____________________________ ____
Patient Name Patient Signature

MOA- Please note that the transfer of these records is for diagnostic purposes only and does not indicate a transfer of routine care.

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