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☐ **Dr. Balraj Mavi MD,CCFP**
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AUTHORIZATION REQUEST TO TRANSFER MEDICAL RECORDS TO CLOCKWORK HEALTH GROUP

TO (Name of Doctor/Clinic): _____

Address: _____

PHONE: _____ **FAX:** _____

This will give you full authorization to forward to:

CLOCKWORK HEALTH GROUP

The medical records, or a summary thereof, of the following person (s):
Most relevant medical records including pap, mammogram, imaging, and consultation reports within the last five years. Please send first and last procedure reports.

PATIENT'S NAME & HEALTHCARD # (Please Print) **PATIENT SIGNATURE**

_____ _____

(Additional Family Members)

1._____ _____

2._____ _____

WITNESS SIGNATURE **DATE**

_____ _____

Please be advised there may be a fee for transferring records. Thank you for your co-operation and help in performing this service.