



# Medicinal Cannabis Resource Centre

200-460 Nanaimo Street

Vancouver, BC V5L 4W3

Phone: 1-855-537-6272 Fax: 604-909-1890

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## CONSENT TO OBTAIN MEDICAL RECORDS

Dear Dr. \_\_\_\_\_  
(Your family physician or specialist's name)

Dr. Contact Phone #: \_\_\_\_\_  
(Doctor's office contact phone number)

I, \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Print Name) (Date of Birth DD/MM/YYYY) (Personal Health Number)

I request and herein give my consent that a summary and copies of portions of my medical records can be faxed to:

Dr. Arnold J. Shoichet at the Medicinal Cannabis Resource Centre Inc (MCRCI), at **604-909-1890** for an upcoming health consultation.

The Centre has requested information about my following medical condition(s).

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**Please send the most recent and relevant medical consultations, clinical notes, X-ray or MRI reports, pertaining to the conditions(s) listed above (preferably within the last 1-3 years, however we will accept up to 10 years if nothing more recent on file).**

I realize that there may be a charge to me for this service.

I also consent to you discussing the above in writing or by phone with MCRCI.

Please note this is NOT a transfer of my care to MCRCI.

MCRCI can contact me at: \_\_\_\_\_  
(Phone number and/or e-mail)

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Date DD/MM/YYYY)