Medicinal Cannabis Resource Centre

200-460 Nanaimo Street
Vancouver, BC V5L 4W3
Phone: 1-855-537-6272 Fax: 604-909-1890

CONSENT TO OBTAIN MEDICAL RECORDS

Dear Dr. _____ Dr. Contact Phone #:_____
(*Your family physician or specialist's name*) (*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:

The Medicinal Cannabis Resource Centre Inc (MCRCI), at **604-909-1890** for an upcoming medical consultation.

The Centre has requested information about my following medical condition(s) but not limited to:

_____

_____

_____

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)*