

RECORDS RELEASE FORM

Date: _____

To: _____

I hereby authorize you to release to:
Gurvinder Shaheed, M.D. / Vijay Suhag, MD
Northcal Hematology Oncology inc.

Any information including the diagnosis and records of my treatment or examination.

Patient Name: _____

Signature: _____ Date of Birth: _____

Relationship to Patient: _____