



Howden Medical Clinic

Urgent Care/Family Practice/Cosmetics

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Authorization to Release Information

Please be advised that I _____, with
the Date of Birth _____ and Health Card Number
_____ hereby authorize Howden Medical Clinic
to release my Medical Records to :

Name: _____ Fax : _____

Thank you for your assistance.

Patient Name: _____

Signature : _____

Date: _____