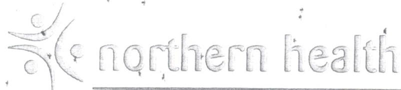


AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORD INFORMATION

Patient Name: White (Last Name) Robert (First Name) Alan (Middle Initial) — Medical Record No. (if available) [redacted] — Date of Birth [redacted]

Address: PO Box 931 (Street) McBride (City) BC (Province) — Telephone #: ~~250~~ (604) 229-0924

The undersigned hereby authorizes/requests the McBride Hospital + medical Clinic (Health Care or Health Services Provider)

To provide: myself (Name of Third Party)

Address: same (Street) (City) (Province) (Postal Code)

with photocopies from my medical records. The reason for this request is: legal purposes

The records I authorize to be provided are as follows:

	ENTER DATES OF TREATMENT		ENTER DATES OF TREATMENT
☐ Emergency Records		☐ Pathology Reports	
☐ Hospital/ Inpatient Records		☐ Radiology Reports	
☐ Clinic/ Outpatient Records		☐ Pharmacy Reports	
☐ Laboratory Reports		☐ Other (Please specify, E.g. Fetal Monitoring Strips, X-ray films, etc.)	

☑ All records

R. White — Signature of Patient

Val Keim — Signature of Witness

Apr 11/13 — Date

IF THE PERSON SIGNING IS NOT THE PATIENT, STATE RELATIONSHIP AND AUTHORITY TO DO SO.

Signature of Legal Representative — Relationship — Name of Legal Representative (Please Print) — Date

1. This authorization may be revoked or amended in writing at any time prior to the expiration date except where action has been taken in reliance on the authorization.
2. This authorization must contain the original signature of:
   a) The patient, or the parent or legal guardian if the patient is under 19 years of age and unmarried*; or the legal representative if the patient is deceased or has been certified mentally incompetent, and
   b) The witness to the patient's or legal representative's signature.
3. Requests for release of information must be dated after treatment dates.
4. If the patient does not read or understand English, the authorization form must be interpreted for the patient. The person who acts as the interpreter **must** sign the form as a witness to confirm that this has been done. Please indicate if the interpreter is related to the patient.

Signature of Interpreter — Name of Interpreter/Relationship to Patient if Any (Please Print) — Date

* For patients between 12 and 19 years of age who wish to authorize their own release of records, please consult the Regional Manager, Client Records & Privacy for guidance regarding the requirements of the *BC Infants' Act*.

McBride and District Hospital
PO Box 663, 1136 - 5th Avenue, McBride, BC V0J 2E0
Telephone: (250) 569-2251; Fax: (250) 569-3369, www.northernhealth.ca

DATE: Nov. 1 2012

TO: Dr. Klein
Squamish B.C.
Phone (604) 892-5688
Fax (604) 892-9727

The following person(s) have recently attended our clinic for medical treatment. May we please have a summary of his/her records. Thank you.

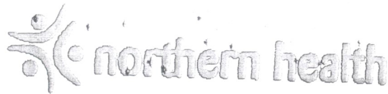
NAME	DATE OF BIRTH
White, Robert	[redacted]

R White
Signature of Patient/Guardian

Pepper
Witness

Dr. Josef Owega
MEDICAL CLINIC
MCBRIDE & DISTRICT HOSPITAL
Box 669, McBride, BC V0J 2E0 Ph (250)569-2251 ext. 200 Fax(250)569-3369

FAXED Nov 1/12



McBride and District Hospital
PO Box [illegible], 1130 - 5th Avenue, McBride, BC V0J [illegible]
Telephone: [illegible], Fax: [illegible], www.[illegible]

DATE: Nov. 1 2012

TO: Dr. Lam
Squamish B.C.
Phone (604) 892-3535
Fax (604) 892-3545

The following person(s) have recently attended our clinic for medical treatment. May we please have a summary of his/her records. Thank you.

NAME	DATE OF BIRTH
White, Robert	[redacted]

NOV 0 2 2012 Only one visit in 2006.
DR Lam

thanks

1 st entry

R. White
Signature of Patient/Guardian

L. Pepper
Witness

Dr. Josef Owega
MEDICAL CLINIC
MCBRIDE & DISTRICT HOSPITAL
Box 669, McBride, BC V0J 2E0 Ph (250)569-2251 ext. 233 Fax(250)569-3306

NOV 0 1 2012

TCI URGENT	TCI ROUTINE
CHART PULL	FILE

McBride and District Hospital
PO Box 669, 1136 - 5th Avenue, McBride, BC V0J 2E0
Telephone: (250) 569-2251, Fax (250) 569-3369, www.northernhealth.ca

DATE: NOV. 1 2012

TO: Dr. Barnard
Barriere B.C.
Phone (250) 672-9795
Fax (250) 672-9726

The following person(s) have recently attended our clinic for medical treatment. May we please have a summary of his/her records. Thank you.

NAME	DATE OF BIRTH
White, Robert	[redacted]

R. White
Signature of Patient/Guardian

L Pepper
Witness

Dr. Josef Owega
MEDICAL CLINIC
MCBRIDE & DISTRICT HOSPITAL
Box 669, McBride, BC V0J 2E0 Ph (250)569-2251 ext. 200 Fax(250)569-3369

FAXED NOV 1/12

McBride and District Hospital
PO Box [illegible], [illegible] - 5th Avenue, McBride, BC V0J [illegible]
Telephone: ([illegible]) [illegible], Fax ([illegible]) [illegible], www.[illegible]

DATE: Nov. 1, 2012

TO: Dr. Faridi
Kamloops B.C.
Phone (250) 828-9511
Fax (250) 828-1823

The following person(s) have recently attended our clinic for medical treatment. May we please have a summary of his/her records. Thank you.

NAME	DATE OF BIRTH
White Robert	[redacted]

No records available!!
Nov 2/12

Signature of Patient/Guardian

Witness

Dr. MAJID FARIDI, INC.
Majid Faridi, F.R.C.S.
302 - 444 Victoria Street
Kamloops, BC V2C 2A7
Ph. [illegible] 828-9511 Fax 250-828-1823

Dr. [illegible]
MEDICAL CLINIC
MCBRIDE & DISTRICT HOSPITAL
Box [illegible], McBride, BC V0J [illegible] Ph ([illegible]) [illegible] ext. [illegible] Fax ([illegible]) [illegible]

2013-04-11 ROBERT WHITE /
Chronic neck pain and cracking since arrest last yr. Still c/o periph neuropathy sx, L>R hands. No past records available.
Pt very paranoid about government involvement and "coverups", not frankly psychotic though.
O/ Decr ext, L lat flex and rot'n. Neuro subjective decr sens'n, power testing inconsistent. Reflexes OK.
A/ mech neck pain, ?plexopathy
P/ MT (no $), heat and stretch, neuro

ATTENDING: OWEGA, JOSEF AUTHOR: OWEGA, JOSEF