COLLEGIATE
Sports Medicine

5121 47St
Red Deer, AB,T4N 1R8
Clinic: 403-314-4458
Fax: 403-314-4227

Re: Authorization for Collegiate Sports Medicine to Release Medical Records

1. Client Information

Last Name _____ First Name _____ Date of Birth (yyyy/mm/dd) _____

Legal Guardian Information (If Applicable) **AHC#:** _____

Last Name _____ First Name _____ Relationship _____

2. Records Requested

Body Part: _____ ☐ Left ☐ Right

Date(s) of Records:	Start Date:	End Date:
☐ Chart Records (Body part/ Dates)		
☐ Whole Chart		
☐ Initial Assessment Report		
☐ Interim Report		
☐ Discharge Report		
☐ Other: _____		

3. Client Authorization

I, the client or the legal guardian named above, hereby authorize the release of all medical records requested above to:

Name: _____ **Attn:** _____

Address: _____

City: _____ **Prov:** _____ **Postal Code:** _____

Phone: _____ **Fax:** _____

Send by: ☐ Fax ☐ Mail ☐ To Pickup

Date Signed: _____ _____
Signature of Client/Legal Guardian

_____ _____
Print Name of Witness Signature of Witness