



PATIENT INFORMATION

Form with fields: Last Name, First Name, Middle Name, Personal Health Number (PHN), Date of Birth (MM/DD/YYYY)

PATIENT REPRESENTATIVE INFORMATION

If authorization is given by a person other than the patient, proof of guardianship or appointment as representative must accompany this form.

Form with fields: Last Name, First Name, Relationship to Patient

WITNESS INFORMATION

Form with fields: Last Name, First Name, Telephone Number, Address, City, Postal Code

RECIPIENT INFORMATION

The PharmaNet record of the Patient identified above should be delivered to the Recipient identified here.

Form with fields: Last Name, First Name, Company/Organization, Address, City, Postal Code, Telephone Number, Fax Number, File or Reference Number (if applicable)

AUTHORIZATION

I hereby consent to the Ministry of Health releasing my PharmaNet patient record of [DATE] - [DATE]

to the recipient named above for the purposes of [REASON FOR REQUEST, E.G. LITIGATION, COMPENSATION CLAIM, ETC.]

in accordance with the Pharmaceutical Services Act [SBC 2012] c.22, s.23(2)(b).

Form with fields: Patient Signature, Witness Signature, Date

Send this form to PharmaNet Profiles Services by fax to 250-953-0432 or by mail to PO Box 9652 STN PROV GOVT, Victoria, BC, V8W 9P4

Personal information on this form is collected, used and disclosed under the authority of, and in accordance with, the British Columbia Pharmaceutical Services Act and Freedom of Information and Protection of Privacy Act.

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