BRITISH COLUMBIA | Ministry of Health

CONSENT FOR RELEASE OF PHARMANET PATIENT RECORD

PATIENT INFORMATION

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.

Last Name	First Name	Relationship to Patient

WITNESS INFORMATION

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.

Last Name	First Name	Company/Organization

Address	City	Postal Code

Telephone Number	Fax Number

Email Address (critical for processing)	File or Reference Number (if applicable)

AUTHORIZATION

I hereby consent to the Ministry of Health releasing my PharmaNet patient record of _____ (PATIENT RECORD START DATE (YYYY/MM/DD)) - _____ (PATIENT RECORD END DATE (YYYY/MM/DD))

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).

Patient Signature	Witness Signature

Date	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. If you have any questions about the collection or use of this information, call Health Insurance BC from Vancouver at 1-604-683-7151 or from elsewhere in B.C. toll free at 1-800-663-7100.

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