Conceptia

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

V. 26/01/2023

I, the undersigned, _____ born on _____
(Print Name)

and _____ born on _____
(Print Partner Name – If applicable)

authorize _____
(Doctor, Health Center or Hospital)

to release my medical records or the documents specified below to the Conceptia Clinic:

_____

_____

_____

Name: _____ Signature: _____ Date: _____

Partner: _____ Signature: _____ Date: _____
(If applicable)

Clinical reviewer: _____ Signature: _____ Date: _____

Please choose one of the following:

- Fax: 506 862-7571
- E-mail: info@conceptia.ca
- Regular mail: Conceptia Clinic, Hôtel-Dieu Pavilion, 35 Providence street, Moncton NB E1C 8X3

Keep in mind that any information that is communicated via fax or e-mail is not entirely safe and may be intercepted and used by third parties other than the intended recipient