

*Patient label here*

## MEDICAL or COUNSELLING RECORDS TRANSFER REQUEST

Copy of records **TO:**

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Copy of records **FROM:**

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### INSTRUCTIONS: *(please check all that apply)*

- Complete chart required, including medical and counselling history
- Counselling history only
- Medical history only
- Specific notes/test results: \_\_\_\_\_
- Immunizations only
- Patient/client transferring out

I wish to:

- have the records delivered by regular mail at the address above
- have the records delivered by courier
- pick the records up in person

### SIGNATURE

**Relationship to the individual (please check one)**

- Self*    *Substitute Decision Maker*    *Other* \_\_\_\_\_

Dalhousie Student Health & Wellness is required to verify an individual's authority to access information before releasing personal health information. A clear photocopy of one piece of government issued personal identification will be required for fax/mail requests (ensure photocopy shows your photograph and your signature).

I consent to my physician, psychiatrist, psychologist, counsellor, or social worker reviewing my personal health information in order to provide it to me as requested on this form. I understand that there may be a fee to transfer my records, including any fee associated with delivery by regular mail or courier. Dalhousie Student Health & Wellness may provide an estimate of any fees to me prior to release of my record(s), and fees may be payable by me in advance of any access.

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**Signature**

**Date**

**Office use only:** Date Request Received \_\_\_\_\_ Date Record  
Provided \_\_\_\_\_