Medical Release Form

I _____, date of birth_____
Consent to the release of my personal CCMI Health record information to the following physician and/or facility:

Physician or Facility	Dr. Daniel Collins
Address	130-180 Wilson Street, Victoria BC
Phone Number	250-475-1522 ext 1
Email Address	westside@acaciahealth.ca

I understand the purpose for which consent is given and that I can withdraw or limit my consent at any time by providing written notice to CCMI.

Dated this_____ day of _____, year_____

_____ _____
Patient's Name Signature of Patient/Guardian

_____
Witness Signature

Acacia Health
Suite 130-180 Wilson St Westside Village,
Victoria B.C., V9A 7N6
Tel: (250)-475-1522 / Fax: (250)-590-6430
www.acaciahealth.ca