



**REQUEST FOR PATIENT INFORMATION (Circle of Care)**

**Date:**

**Requestor Name/Organization:**

**Requestor Telephone:**

**Requestor Fax Number:**

**Patient's Full Name:**

**Date of Birth:**

**Health Card Number:**

**Approximate date of Visit:**

**Please Mark Information Required:**

- History & Physical     Consultation Report     Operative Report     Discharge Summary
- Emergency Report     Laboratory Reports     Diagnostic Imaging
- Cardiorespiratory (circle): ECG, Echo, Stress Test, Holter Monitor, Pulmonary Function Test
- Progress Note     Psychiatric Notes     Orders
- Other

**Timeline Required (please indicate):**  Urgent  4 hours  24 hours  48 hours

**Contact Information:**

**Release of Information Hours: Monday to Friday 7:00 am to 5:00 pm**

**Fax Number: 519-740-4958**

**Emergency Department: Sunday to Saturday- 5:00 pm to 7:00 am**

**Fax Number: 519-740-4921**

**Confidentiality Notice**

This information is directed in confidence solely to the person or organization named above and may not otherwise be read distributed, copied or disclosed. Therefore, this information should be considered strictly confidential and only used for the purpose of the intended recipient. If you have received this fax in error, please notify the sender immediately. Please return the fax to the sender and shred all copies received in error. Thank you for your assistance