Prior to your visit with Dr. Goldade we ask that you PRINT the following Release Form and Sign it. This form gives Dr. Goldade (and staff) permission to gather information if necessary from organizations such as schools and/or consultants.
You may then scan/email it back to drgoldade@gmail.com, fax it to 403-255-9322, mail it to our office or bring it to your appointment with Dr. Goldade.

Dr. Roxanne Goldade
Paediatrician
Suite 109, 1033 Southport Road
Calgary Alberta T2W 3X6
www.drgoldade.com

RECORDS RELEASE AUTHORIZATION

To whom it may concern:

Regarding:

Patient Name:
Patient Date of Birth:
Address:
Patient Phones Numbers:
  Home Phone:
  Business Phone:
  Mobile Phone:
  Patient email (if applicable):
Other account information required to communicate via the Services (if applicable):

I hereby authorize and request release to Dr. Roxanne Goldade, associates or designates, any or all medical records concerning my child. I also authorize agencies or clinics to be able to contact Dr. Goldade and her office and allow Dr. Goldade to contact them and provide information to them (via mail, fax, email and telephone).

I also understand that if there were a request for reproduction of medical records (which is an uninsured service) fees MAY be charged for providing this information. In accordance with regulations of the Health Information Act, I maybe invoiced a basic fee (usually $25) plus additional fees as outlined on her website.

Parent/Guardian or Patient Name: Date:

Parent/Guardian or Patient Signature: Date: