BOUNDLESS MEDICAL

Dr. Stuart Bax
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CONSENT FORM FOR RELEASE OF MEDICAL INFORMATION

Patient Information:

- **Patient's Full Name:** _____
- **Date of Birth:** _____
- **PHN:** _____
- **Phone Number:** _____

Purpose of Release:

I, the undersigned, hereby authorize the release of my medical records, to Boundless Medical for the purposes of continued care.

Recipient of Information:

- **Name of Recipient:** Dr. Stuart Bax
- **Relationship to Patient:** Family Physician
- **Address of Recipient:** 50 Electronic Ave, Port Moody, BC V3H 0L9
- **Fax Number:** (844) 705-0165

Rights and Acknowledgements:

1. I understand that I have the right to inspect and obtain a copy of the medical records to be released.
2. I understand that my medical information will be protected and handled in accordance with applicable laws, including HIPAA (Health Insurance Portability and Accountability Act) regulations.
3. I understand that the release of my medical information may include sensitive and confidential information. I authorize the release of such information unless otherwise specified.

Patient's Signature:

By signing below, I acknowledge that I have read and understand this form, and I give my consent for the release of the described medical information as stated above.

- **Patient's Signature:** _____
- **Date:** _____