



Authorization for Release of PharmaNet Patient Record

I, _____
Last Name *First Name* *Middle Name*

Date of Birth (Day/Month/Year) *Personal Health Number*

hereby authorize the College of Pharmacists of British Columbia to release my PharmaNet Patient Record:

From: _____ **To:** _____
Date (Day/Month/Year) *Date (Day/Month/Year)*

To: **Lawyer's Name** _____
Company's Name _____
Address _____

Telephone _____
Fax _____
File # _____

Patient's Signature *Date*

Witness' Signature *Date*

Witness Name _____
Address _____

Occupation _____

If authorization is given by other than the patient, please contact the College of Pharmacists of BC for information on the required legal documents.