Alevia®
Health and Wellness Centre™

1251 Huron Street, Unit 111
London, Ontario N5Y 4V1
Tel 519.453.7117 • Fax 519.453.6540

PATIENT RECORD REQUEST

Date: ___________

Patient Name: _________________ Date of Birth: ________________
Patient Number: _______________

Attention To: ____________________________
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I, ______________________ hereby request that your facility fax/send the following medical records and diagnostic test results: post operative reports, diagnostic imaging, radiographs, lab tests, accident reports, daily progress notes, physical exam notes; to Alevia Health and Wellness Centre in London.

Your assistance in promptly forwarding copies of _________________ files will help us provide better, more efficient care for our patient. We appreciate your assistance and if you have any questions or need clarification please call our office at (519) 453-7117.

In good health, Alevia Health and Wellness Centre

_______________	_______________	_____________
Patient Name-Print	Signature	Date

_______________	_______________	_____________
Witness	Signature	Date