PAEDIATRIC
CARDIOLOGY

Norman N. Musewe
M.D., F.R.C.P. (C)

CONSENT TO RELEASE MEDICAL INFORMATION

I, _____ give consent to **Dr. Norman Musewe** to release medical
(PATIENT/GUARDIAN FULL NAME)

records related to _____,
(PATIENT'S FULL NAME)

To be sent to:

ATTEN:_____

ADDRESS:_____

_____

PHONE #: _____

FAX #: _____

Patient/Guardian Signature:_____ Date:_____

Witness:_____ Date:_____

(OFFICIAL USE ONLY)

N.B Please emailed signed and completed form to moyo@normanmusewemd.com.

Suite 315
6633 Highway 7 East
Markham, Ontario
L3P 7P2

Tel: (905) 471-3700
Fax: (905) 471-3702