Alpha-1 Canadian Registry

PHONE: 1-800-352-8186 | FAX: 416-603-5020
EMAIL: INFO@ALPHA1CANADIANREGISTRY.COM

UHN-TORONTO WESTERN HOSPITAL
399 BATHURST STREET
7 EAST RM 445
TORONTO, ON M5T2S8

RELEASE OF MEDICAL INFORMATION

Respirologist:_________________________

Address:_____________________________

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Phone:_______________________________

Fax:_________________________________

Family Dr: ____________________________

Address:______________________________

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Phone:_______________________________

Fax:__________________________________

This is a request for information for Patients Full Name: _________________________________

Date of Birth (dd/mmm/yy): _ _/_ _ _/ _ _ Phone: _________________ Email:________________

Address:____

Request for: Demographics / Medical History / Blood test results / Pulmonary Function Tests

I authorize the release of the above information to:

Alpha-1 Canadian Registry Data Management Centre
UHN-Toronto Western Hospital 399 Bathurst St.
East Wing 7th Floor, Room 445
Toronto, Ontario M5T 2S8 Fax: 416-603-5020

Patient Signature:___________________ Date:___________ Witness Signature:________________

Upon completion, you can mail or fax this form to the registry address above.