Interior Health
Every person matters

Provider Association to Patient's IH Record
Patient Addition or Removal Request Form

Date of Request:_____
dd/mmm/yyyy

If you received misdirected records from another Health Authority or laboratory organization, do not complete this form; please send your correction request to the appropriate referral facility.
Any forms that are not from IH will not be processed.

Read carefully and select appropriate option

Please ADD my name to the noted patient's record

☐ **I am now responsible for this patient's care**
This will remove any current Family Provider associated on the IH patient record; they will no longer receive reports for this patient.

Please REMOVE my name from the noted patient's demographic information as:

☐ **I have never been associated with this patient's care**

OR

☐ **I used to be associated with this patient's care, but no longer involved**

Patient Legal Name:_____
Please print clearly

Date of Birth:_____ PHN:_____
dd/mmm/yyyy

Requesting Provider **Full** Name:_____
Please print clearly

Provider Signature:_____

please provide contact info below for any follow up that may be required

Contact Email_____
(no patient specific information to be faxed back to provider office)

Requesting Clinic Contact Name:_____

Requesting Clinic Phone:_____

Additional Comments:_____

Fax completed form and any misdirected Interior Health reports received to:
Interior Health toll free at: 1-855-491-6789

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