



MEDCARE CLINICS @ WALMART MARKHAM

500 Copper Creek Drive (inside Walmart) • Markham, Ontario • L6B 0S1, Canada

Phone: (905) 205 1400 • Fax: (905) 205 0088

Email: markham@medcareclinics.com • Web: www.medcareclinics.com

Request to Release Patient Health Information to MedCare Clinics

PATIENT INFORMATION	
Name: _____	Date of Birth: _____
Address: _____	Apt. #: _____
City: _____	Province: _____
Postal Code: _____	Telephone #: _____
Health Card #: _____	

PERMISSION TO SHARE: I give my permission to share my protected health information:	
FROM:	TO:
Name: _____	MedCare Clinics @ Walmart Markham
Address: _____	500 Copper Creek Drive (inside Walmart)
_____	Markham, Ontario – L6B 0S1, Canada
Telephone #: _____	Tel #: 905-205-1400 Fax #: 905-205-0088
Fax #: _____	Email: vaughan@medcareclinics.com
	Send By:
	<input type="checkbox"/> Mail <input type="checkbox"/> Fax <input type="checkbox"/> Patient Pick-up <input type="checkbox"/> E-Mail

INFORMATION REQUESTED TO BE RELEASED	
<input type="checkbox"/> All Medical Record	<input type="checkbox"/> Pathology Reports
<input type="checkbox"/> Operative Reports	<input type="checkbox"/> X-Ray/Lab/MRI/CT Scan Reports
<input type="checkbox"/> Other (please specify below): _____	

DISCLAIMER	
<p>I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I consent to MedCare Clinics @ Walmart Markham, including its staff and providers, to obtain my health information. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. MedCare Clinics @ Walmart Markham keeps all personal and health information strictly confidential and secure. No medical or health information will be provided over the phone. MedCare Clinics @ Walmart Markham will not disclose any personal or health information to any third party (without prior consent). I acknowledge that I will be responsible for any associated fees to obtaining my medical records. I acknowledge that I have read and fully understand this form, disclaimers and policies, including data breach of personal information. By signing this document, I understand that I agree to waive any and all claims that I have or may have in the future against the MedCare Clinics @ Walmart Markham its directors, affiliates, owners/operators, employees, physicians (collectively the "releasees"). I agree to release the Releasees from any and all liability for any loss, damage or injury that my next of kin or I may suffer as a result of the improper release of medical information, malpractice, including negligence, breach of contract, privacy breach, data breach or breach of any statutory or other duty of care.</p>	
Date: _____	Signature: _____
Date: _____	Signature of parent/guardian: _____