MEDCARE CLINICS @ NIAGARA SQUARE

7555 Montrose Road, Unit # E2 • Niagara Falls, Ontario • L2H 2E9, Canada
Phone: (289) 292 0441 • Fax: (289) 292 0451
Email: niagara@medcareclinics.com • Web: www.medcareclinics.com

Release Request of 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:
MedCare Clinics @ Niagara Square 7555 Montrose Road – Unit # E2 Niagara Falls, Ontario, L2H 2E9, Canada Tel #: 289-292-0441 Fax #: 289-292-0451 **All records will be sent via fax**	Name: _____ Address: _____ _____ Telephone #: _____ Fax #: _____

INFORMATION REQUESTED TO BE RELEASED

- ☐ All Medical Record
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ X-Ray/Lab/MRI/CT Scan Reports
- ☐ Other (please specify below): _____

_____

DISCLAIMER

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 @ Niagara Square, including its staff and providers, to release my health information and medical records to the above mentioned. 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 @ Niagara Square keeps all personal and health information strictly confidential and secure. No medical or health information will be provided over the phone or via email. MedCare Clinics @ Niagara Square 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 releasing my medical records. Records will only be release once payment is made in full. 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 @ Niagara Square, 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.

Date: _____ Signature: _____

Date: _____ Signature of parent/guardian: _____

OFFICE USE ONLY
Payment amount: _____ Payment method: _____ Scanned to EMR: [ ] Records sent by: _____