# MEDCARE CLINICS @ SCOTT STREET

387 Scott Street, Unit A2C • St. Catharines, Ontario • L2M 3W2 - Canada
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## Release Request of Patient Health Information from 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: |
|---|---|
| Scott Street Medical Centre (MedCare Clinics)<br>387 Scott Street – Unit A2C<br>St. Catharines, Ontario – L2M 3W2<br>Tel #: 905-646-8383 Fax #: 905-646-0202<br><br>**All records will be sent via fax** | Name: _____<br><br>Address:_____<br><br>_____<br><br>Telephone #: _____<br><br>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 @ Scott Street (Scott Street Medical Centre), 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 @ Scott Street (Scott Street Medical Centre) 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 @ Scott Street (Scott Street Medical Centre) 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 @ Scott Street (Scott Street Medical Centre), 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: _____