MEDCARE CLINICS @ SCOTT STREET
387 Scott Street, Unit A2C • St. Catharines, Ontario • L2M 3W2 - Canada
Phone: (905) 646 8383 • Fax: (905) 646 0202
Email: stc@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: ____________________	Scott Street Medical Centre (MedCare Clinics)
Address: ____________________	387 Scott Street – Unit A2C
____________________	St. Catharines, Ontario – L2M 3W2
	Tel #: 905-646-8383 Fax #: 905-646-0202
	Email: stc@medcareclinics.com
Telephone #: ____________________	Send By:
Fax #: ____________________	Mail Fax Patient Pick-up E-Mail

INFORMATION REQUESTED TO BE RELEASED

All Medical Record	Pathology Reports
Operative 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 Scott Street Medical Centre, 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. 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. 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 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 @ 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: ______________________________