MEDCARE CLINICS @ GEORGETOWN MEDICAL CENTRE

333 Mountainview Road South, Unit 2 • Georgetown, Ontario • L7G 6E8, Canada
Phone: (905) 877-0877 • Fax: (905) 877-8455
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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:
MedCare Clinics @ Georgetown Medical Centre 333 Mountainview Road South – Unit # 2 Georgetown, Ontario, L7G 6E8, Canada Tel #: 905-877-0877 Fax #: 905-877-8455 Email: georgetown@medcareclinics.com **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 @ Georgetown 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 @ Georgetown 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 @ Georgetown 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 @ Georgetown 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: _____

Name: _____ Signature of parent/guardian: _____