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

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 @ Walmart Markham 500 Copper Creek Drive (inside Walmart) Markham, Ontario – L6B 0S1, Canada Tel #: 905-205-1400 Fax #: 905-205-0088 **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 @ Walmart Markham, 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 @ Walmart Markham 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 @ 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 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 @ 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.

Date: ________________ Signature: ____

Date: ________________ Signature of parent/guardian: ______________________________________

OFFICE USE ONLY
Payment amount: ________ Payment method: __________ Scanned to EMR: [ ] Records sent by: ___________